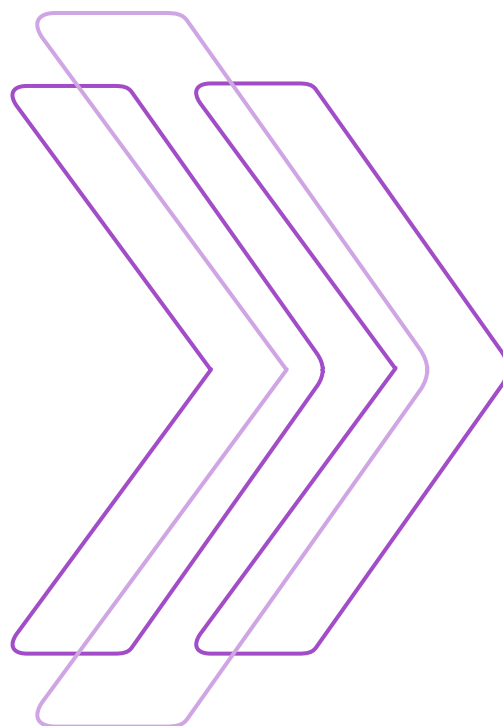


The courage of compassion

**Supporting nurses and midwives
to deliver high-quality care**

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September 2020



This independent report was commissioned by The RCN Foundation. The RCN Foundation is a charity and grant-maker that is committed to supporting and strengthening nursing and midwifery to improve the health and wellbeing of the public. This report is editorially independent and all views and conclusions in the report are those of the authors.

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Foreword

This report has been written against the backdrop of the biggest global public health crisis in a generation. For nurses and midwives, the Covid-19 pandemic has exacerbated the issue of excessive demands on a workforce already at risk of stress and burnout. Added to this, the long-term effects of post-traumatic stress disorder are now a significant risk for those who have been on the front line during the pandemic. The Boorman review (2009) previously highlighted the key role played by the health of staff in delivering effective and efficient health care within the NHS. It also flagged the high rates of presenteeism, absence and attrition that existed within the nursing and midwifery professions.

This new report demonstrates not only that there is much to do if we are to bring about the cultural change needed to create a fully healthy and vibrant workforce, but also that achieving this change is no longer optional.

What is heartening, and highlighted in this report, is that examples of excellent practice to improve nurse and midwife wellbeing and tackle the underlying causes of mental health problems do exist in different parts of the workforce. This report showcases the many ways in which individuals and organisations are making a real difference to nurses and midwives across the four nations of the United Kingdom (UK).

The mental health of the nursing and midwifery profession has been a key and ongoing priority for the RCN Foundation over the past three years. In commissioning this review, the RCN Foundation was determined that this would be a report that not only delivered powerful messages about the state of the professions' mental health, but also one that outlined the tangible steps that should be undertaken to tackle the issue.

The eight recommendations set out in this report provide a blueprint for action. We recognise that the path to achieving positive outcomes for the wellbeing of the nursing and midwifery workforce is a difficult one, particularly in the face of the current climate.

Nurses and midwives form a vital part of the tapestry of health and care provision – at every level, in every setting and in every corner of the UK.

They have demonstrated their value time and again, not least in the fight against Covid-19. As the largest proportion of the health and care workforce, we simply cannot ignore the urgent need, highlighted in this report, for transformational change to enable them to flourish and thrive in their work.

We want to thank The King's Fund and all the individuals who contributed to and helped to produce this report. We hope you will join us in advocating for a culture of compassion within health and social care, so that nurses and midwives are given the support they need to improve not only their own wellbeing, but also that of their patients, residents and communities.

Baroness Watkins of Tavistock

Alternate Chair,
Nursing Now Campaign

Professor Jane Cummings CBE

Chair,
RCN Foundation

Key messages

- The Covid-19 pandemic has put the UK health and care workforce under unprecedented pressure. The workforce had been struggling to cope even before the pandemic took hold. Staff stress, absenteeism, turnover and intentions to quit had reached alarmingly high levels in 2019, with large numbers of nurse and midwife vacancies across the health and care system. And then the Covid-19 pandemic struck.
- The impact of the pandemic on the nursing and midwifery workforce has been unprecedented and will be felt for a long time to come. The crisis has also laid bare and exacerbated longstanding problems faced by nurses and midwives, including inequalities, inadequate working conditions and chronic excessive work pressures.
- The health and wellbeing of nurses and midwives are essential to the quality of care they can provide for people and communities, affecting their compassion, professionalism and effectiveness.
- This review investigated how to transform nurses' and midwives' workplaces so that they can thrive and flourish and are better able to provide the compassionate, high-quality care that they wish to offer.
- Nurse and midwives have three core work needs that must be met to ensure wellbeing and motivation at work, and to minimise workplace stress:
 - autonomy – the need to have control over their work lives, and to be able to act consistently with their values.
 - belonging – the need to be connected to, cared for, and caring of others around them at work, and to feel valued, respected and supported.
 - contribution – the need to experience effectiveness in what they do and deliver valued outcomes.

Key recommendations

The report sets out eight key recommendations, alongside an accompanying set of detailed practical recommendations. A full list of all recommendations is

provided in Appendix 1. They are addressed to all leaders who influence the workplace experience of nursing and midwifery staff. Regulators, improvement bodies and partners in health and social care should support organisations to effectively implement all recommendations set out in this report and should help share and spread good practice.

Key recommendation 1: Authority, empowerment and influence

Introduce mechanisms for nursing and midwifery staff to shape the cultures and processes of their organisations and influence decisions about how care is structured and delivered.

Key recommendation 2: Justice and fairness

Nurture and sustain just, fair and psychologically safe cultures and ensure equity, proactive and positive approaches to diversity and universal inclusion.

Key recommendation 3: Work conditions and working schedules

Introduce minimum standards for facilities and working conditions for nursing and midwifery staff in all health and care organisations.

Key recommendation 4: Teamworking

Develop and support effective multidisciplinary teamworking for all nursing and midwifery staff across health and care services.

Key recommendation 5: Culture and leadership

Ensure health and care environments have compassionate leadership and nurturing cultures that enable both care and staff support to be high-quality, continually improving and compassionate.

Key recommendation 6: Workload

Tackle chronic excessive work demands in nursing and midwifery, which exceed the capacity of nurses and midwives to sustainably lead and deliver safe, high-quality care and which damage their health and wellbeing.

Key recommendation 7: Management and supervision

Ensure all nursing and midwifery staff have the effective support, professional reflection, mentorship and supervision needed to thrive in their roles.

Key recommendation 8: Learning, education and development

Ensure the right systems, frameworks and processes are in place for nurses' and midwives' learning, education and development throughout their careers. These must promote fair and equitable outcomes.

Our call to action

We are calling on all health and social care leaders to lead with compassion by implementing all the recommendations in this report. Organisations with cultures of compassion promote fairness and foster individual, team and organisational wellbeing. They meet nurses' and midwives' fundamental needs for autonomy, for belonging and to be able to make an effective contribution in their work, which in turn improves care quality and efficiency, and better promotes the wellbeing of the patients, people and communities they serve.

Acknowledgements

Many people have gone above and beyond in contributing to this review. Without them, this report would not have been possible.

We would like to thank all of those who spoke to us in interviews and focus groups: nurses, midwives and nursing and midwifery staff, students, researchers, local and national leaders, and staff from representative, regulatory and improvement bodies and government departments across the four UK countries. Despite the enormous pressures that they were under, they gave their time to provide the insights into nursing and midwifery that have shaped this report and its recommendations. They also shared their lived experiences of working in nursing and midwifery.

We would also like to thank the external peer reviewers who provided wise feedback on early drafts of this report, helping us to target and refine our recommendations and ensuring that they better reflected the varying contexts of nursing and midwifery across the UK.

Finally, thanks also to our colleagues at The King's Fund who shared their wealth of knowledge and experience with us, reviewed drafts, helped to facilitate focus groups and designed and edited the report.

A list of organisations that were consulted by the review team can be found in Appendix 3.

1 Introduction

It takes a remarkable person to be a nurse. This is a profession where joy meets sadness, where courage must outweigh fear. This is rewarding, this is challenging, this is nursing.

(Royal College of Nursing 2012)

In all cultures, the midwife's place is on the threshold of life, where intense human emotions, fear, hope, longing, triumph, and incredible physical power-enable a new human being to emerge. [The midwife's] vocation is unique.

(Sheila Kitzinger, International Confederation of Midwives 2020)

During the Covid-19 pandemic, nurses and midwives have been courageous and compassionate, giving us a clear view of the values they embody every day in their work. Communities across the UK have shown commitment to supporting them, now and in the future. This report provides a comprehensive action plan for leaders to enable nurses and midwives to flourish and thrive in their work and provide compassionate, high-quality care.

The report is aimed at all those who can influence the work lives of nurses and midwives, including organisational and national nursing and midwifery leaders, workforce and people development professionals, operational managers, national bodies, ministers and governments. Nursing and midwifery bodies should grasp this crucial moment in time by aligning together to positively transform the work experience of all in these professions. All are urged to show the courage and compassion that nurses and midwives have shown by in turn committing to transforming their workplaces for a better future.

The report is also written for all nursing and midwifery staff in order that they can have a more comprehensive understanding of research evidence about how their workplaces affect their practice and their wellbeing.

The impact of the pandemic on the nursing and midwifery workforce has been unprecedented and will be felt for a long time to come. The crisis has also laid bare and exacerbated longstanding problems. These problems – many of which are discussed in this report – predate the pandemic and unless we act

to bring about change, they will continue. We have also seen examples of radical innovation and new ways of working emerging in response to the crisis, which must be built upon and systematised.

The pandemic has highlighted the health consequences of discrimination, inequalities, exclusion and racism experienced by communities across the UK, and there has been a disproportionate impact on health and care staff from minority ethnic backgrounds (see 'A note on language', below). The powerful global response of the Black Lives Matter movement to the killing of George Floyd in the United States (US) has raised awareness of the longstanding need for urgent, comprehensive and sustained action. We address these issues from the perspective of nursing and midwifery staff in this report, recognising that fairness and justice are fundamental to our communities and to our collective wellbeing.

A note on language

In this report, we use the term 'patient' in addition to describing care provided to 'people'. The term 'patient' is commonly used operationally in the NHS, in government policy documentation (for example, in the NHS Constitution for England) and in academic literature, but not in all health settings. It is not typically used in social care or midwifery settings.

We use the term 'people from minority ethnic backgrounds' to denote people belonging to ethnic groups that are a minority in the context of the UK population. There are some exceptions when we are referring to data sources that use other terminology, such as 'Black and minority ethnic (BME)'.

The terms 'diversity' and 'inclusion' are sometimes used to mean the same thing, but we see a key difference between them. Diversity is a description about differences of background, thought and experience present within a given staff group. Inclusion is a more contested term and has been defined in various ways (Ross *et al* 2020). We see it as relating to the 'commitment to treat everyone with equal respect and significance' and therefore key to making the most of a diverse workforce (West *et al* 2015).

Aims and scope

The aim of this report is to show how to transform nurses' and midwives' workplaces so that they can thrive and flourish and are better able to provide the compassionate, high-quality care that they and those they serve wish them to deliver. The report examines the workplace stressors, organisational

cultures, working contexts and leadership styles that impact on nurse and midwife wellbeing and mental health, both before and during Covid-19. It sets out how these can be changed to provide dramatically improved working environments and contexts for nursing and midwifery practice, thereby benefiting nurses, midwives, patients, women, families and communities.

The report's scope covers all nursing and midwifery staff and students, including healthcare assistants and nursing associates. It spans all four UK countries, all types of employer (including the NHS, GP practices, local authorities and the independent sector), all areas of practice and all care settings where nursing and midwifery staff operate, including primary care, secondary care, mental health, community care and social care.

Our remit was to represent the issues across each of the four UK countries, considering the variations in legislation and practice that exist. We have sought to achieve this while recognising that we may not have accounted for the nuances in each of the four UK contexts. Wherever possible, we point out key national differences.

Acute models of care continue to dominate health and care workforce analysis and much of the academic literature. This was evident from the data and literature accessed as part of this review and was reflected in comments from a range of stakeholders that were interviewed. The dearth of robust workforce analytics within many parts of the health and care sector (including social care and general practice) has hampered workforce planning and policy-making, and must be addressed as a national priority to help tackle the workforce crisis. To ensure focus on the key overarching issues, we have not given detailed recommendations specific to the work of each category of nursing and midwifery (such as paediatric nurses, health visitors, community mental health nurses, community midwives, general practice nurses and care home nurses). However, we intend our recommendations to be sufficiently clear, relevant and salient to apply to all.

The review was undertaken by a team from The King's Fund, led by Professor Michael West (Senior Visiting Fellow) and Suzie Bailey (Director of Leadership and Organisational Development). It involved extensive analysis of research literature and data, and engagement across all four countries of the UK with individuals and organisations, including:

- nursing and midwifery staff at a range of levels of seniority and across the acute, mental health, primary care, community care, social care and independent sectors
- nursing and midwifery students
- undergraduate and postgraduate education bodies
- representative bodies and royal colleges
- human resources (HR) and workforce leaders at organisational, regional and national levels
- national bodies and government departments overseeing health and care services in each UK country
- regulators and improvement bodies
- academics and researchers.

A detailed methodology is provided in Appendix 2 and a list of individuals and organisations consulted in Appendix 3.

The focus of the report is on identifying the causes, consequences and solutions in relation to poor wellbeing among nurses and midwives.

In identifying solutions, we have focused on primary interventions. These are interventions that address workplace factors that have an impact on mental health and wellbeing (see 'Interventions to tackle stress at work', below). Organisations should ensure that they meet the needs of their workforce by providing wellbeing support and ensuring that those charged with caring for patients themselves get treatment for ill health. **However, it is critical that organisations also tackle the underlying causes of stress, ill health and poor wellbeing – such as chronic excessive workload, bullying, inadequate supervision, discrimination and poor teamworking – rather than focusing solely on their consequences.**

Interventions to tackle stress at work

Interventions aimed at improving the mental health and wellbeing of staff might be seen to operate on three different levels: primary, secondary and tertiary (Quick *et al* 2013).

Primary interventions are targeted at transforming the workplace factors that cause stress and poor wellbeing, such as through reducing time pressures or giving people more control over their work.

Secondary interventions are targeted at supporting individuals to better cope with environmental stressors and manage stressful contexts, such as through mindfulness or resilience training, in order to reduce the impact of these stressors on health and wellbeing.

Tertiary interventions offer remedial support, seeking to treat mental ill health – for example, through counselling services and programmes supporting individuals to return to work.

Primary interventions are stressor-directed, seeking to modify or eliminate the structural causes of mental ill health and poor wellbeing. Secondary and tertiary interventions, on the other hand, focus on people's responses to stressors (Cooper and Cartwright 1997). They are targeted at individual employees rather than on changing aspects of the organisation.

This report focuses on primary interventions: how the work environments of nurses and midwives can be changed to better support their wellbeing and enable them to thrive and flourish at work. Efforts must be focused on changing the factors that cause stress rather than only on dealing with symptoms.

In approaching the health and wellbeing of staff, it is also important to pay attention to strengths and potential in human behaviour, rather than focusing solely on problems and weaknesses. We can seek to promote positive work environments that encourage work engagement (Schaufeli *et al* 2002). The Institute for Healthcare Improvement, for example, has led an international movement for promoting 'joy in work' in health and care organisations (Institute for Healthcare Improvement undated). Job characteristics associated with greater work engagement include those that create psychological growth by providing challenging, varied work and a

feeling of benefit to self and others as a result of role performance (Saks 2006).

Fundamentally, nurses and midwives are enthusiastic about their roles and clearly have a powerful sense of vocation. National staff survey data for the four UK countries shows that more than 70 per cent of nurses and midwives report being enthusiastic about their jobs (79 per cent in England, 71 per cent in Wales and 76 per cent in Northern Ireland; comparable data is not available for Scotland, though the overall experience score is 6.9 on a 10-point scale) (NHS England 2020a; Gov.wales 2018; Scottish Government 2020; Department of Health 2016). It is their work conditions that corrode their motivation.

What should these interventions look like? The most important first step is to understand the core needs of nurses and midwives at work, how these needs affect wellbeing and motivation, and how they can best be met in the various contexts of nursing and midwifery work. Evidence suggests that interventions are most likely to be effective when they are tailored to the specific contexts and needs of the staff group that they affect, whether at organisation, site or team level, and when they involve and engage staff in shaping and implementing changes (Kinman *et al* 2020; Gray *et al* 2019).

Nurses' and midwives' work lives should be fulfilling and life-enhancing, challenging though their jobs are. Research has clearly shown that positive staff wellbeing significantly improves care quality and safety, patient safety, patient satisfaction, productivity, financial performance, and the sustainability of health and care services (West and Coia 2019; West and Dawson 2018). Poor workplace environments have damaging impacts on both the mental and physical health of nurses and midwives and on the quality of care and services they provide.

Many organisations and bodies across the four UK countries are addressing these issues and many of them are well placed to make these changes happen. They should use this report as a springboard for swift, sustained, systematic and effective change. This is consistent with the health and care system's core purpose, to support and improve the health of our population – of which nurses, numbering some 669,854, and midwives, numbering 37,918, constitute a very large group (Nursing and Midwifery Council 2020c).

It is possible. Some of the positive changes we have seen across the UK in health and social care during the Covid-19 pandemic demonstrate that we can

make radical changes in our structures, systems, processes and cultures when it is necessary – and it is absolutely necessary now to transform for the better the work lives of nurses and midwives.

In this section, we set out some of the key background context for this report: the current picture in terms of staff shortages and levels of stress among the nursing and midwifery workforce, an overview of some of the key causal factors that have an impact on nurse and midwife stress levels, and the consequences of poor nurse and midwife wellbeing for nurses and midwives themselves, their patients, and their organisations. We then map out the report's overarching framework and structure.

Context

The mental health and wellbeing of the nursing and midwifery workforce

Staff shortages

Even before the onset of the Covid-19 pandemic, the health and care workforce was struggling desperately to cope (Health Foundation *et al* 2018). There are more than 100,000 staff vacancies in the NHS in England, representing 1 in 11 of all posts (Beech *et al* 2019); Health and Social Care Northern Ireland (HSCNI) reported approximately 7,500 vacancies in Northern Ireland, representing 1 in 8 posts (Department of Health 2019). There is no official national data on vacancy rates in Wales, but responses from health boards and trusts to a freedom of information (FOI) request from the British Medical Association (BMA) Cymru Wales showed a 6.8 per cent vacancy rate (BMA Cymru Wales undated). In Scotland, as of June 2019, there were 5,124 whole-time equivalent (WTE) vacant posts among clinical staff, representing a 6.4 per cent vacancy rate (NHS National Services Scotland, Information Services Division 2019).

One of the greatest challenges is in nursing, with 43,590 nurse vacancies in England (National Audit Office 2020). By September 2019, the NHS in England had a nursing vacancy rate of 12 per cent, a rise of 1 per cent from September 2017 (National Audit Office 2020). Data from the NHS in Scotland showed that 3,607 nurse and midwife posts were vacant out of a total of 60,812 full-time equivalents (NHS Education for Scotland 2020b). Analysis by the Royal College of Nursing (RCN) Wales in 2019 suggested that there could be around 1,651 nursing vacancies in the Welsh NHS (however, these figures should be treated with caution since the Welsh government does not publish national figures for nursing vacancies) (Royal College of Nursing Wales 2019).

And in Northern Ireland, there are 2,488 nursing, healthcare assistant and nursing assistant vacancies (12.4 per cent) across health and social care according to the latest figures (Department of Health 2020). There has been a 35 per cent reduction in health visitors in England's NHS, from 10,309 full-time equivalents (FTEs) in October 2015 to 6,693 FTEs in April 2020 (some of this reduction is due to the move of some health visiting roles into local government) (NHS Digital 2020). Health visitors in some areas of England are now accountable for caseloads of more than 750 children. The Institute of Health Visiting has argued that it 'is impossible for a single practitioner to be safely accountable for the assessment and care of 750 children and their families' (Institute of Health Visiting 2020). There has also been a 38 per cent decrease in the number of learning disability nurses in the English NHS between September 2010 and September 2019 (National Audit Office 2020).

The King's Fund has identified a large and growing gap between capacity and demand in district nursing services: a significant increase in activity over recent years, both in terms of the number of patients and the complexity of care; a decline in staffing levels, particularly in senior 'district nurse' posts; an increasingly task-focused approach to care; and lack of continuity of care (Maybin *et al* 2016). Inevitably, this is having a negative impact on staff wellbeing, with unmanageable caseloads common and some district nurses leaving the service as a result. The researchers heard of staff being 'broken', 'exhausted' and 'on their knees' (Maybin *et al* 2016).

These issues extend into social care. The adult social care sector was also under huge pressure even before the pandemic and facing many of the same issues as the NHS. There are 1.65 million jobs (1.16 million FTE) in adult social care in England and vacancies were running at 7.8 per cent (122,000) before the pandemic (this has since come down to around 6.6 per cent). The registered nurse vacancy rate in adult social care was 12 per cent. There were 36,000 registered nurses working in adult social care in July 2020 (a decrease of 15,500 over the previous eight years). Around 17 per cent of nurses were on zero-hours contracts, known to be associated with higher rates of staff turnover (Skills for Care 2020). In Wales, there are an estimated 1,600 registered nurses working in care homes, while in Scotland, there were around 6,650 nurses working in the social services sector at the end of 2016, representing just under 10 per cent of the nursing workforce. Care homes for adults employ 64 per cent of this total and 27 per cent are employed by nurse agencies. In all four UK countries, there are high levels of vacancies for nursing in social care (Royal College of Nursing 2020d).

Turnover and intention to quit

There are also high levels of staff turnover across nursing and midwifery. Previous research has shown clearly how workplace factors such as long working hours, poor-quality working environments and lack of supportive leadership influence nurses to leave the profession (Goodare 2017).

More than a quarter of midwives and nurses working in secondary care organisations in England are considering leaving the organisation in which they work (NHS England 2020a). The RCN employment survey 2019 suggested that even more (37 per cent) across the UK were seeking a new job; of these, more than a third were looking for a different job in the NHS and nearly a quarter were looking for a job outside the NHS. The survey also showed that before the pandemic, many were considering working abroad. There has also been an increase in NHS nurses from other European Union (EU) countries quitting following the Brexit referendum (Royal College of Nursing 2019).

A UK-wide RCN survey of 42,000 of its members during May and June 2020 revealed that one-third were considering leaving nursing by the end of the year. Some 44 per cent indicated that the way nursing staff had been treated during the pandemic made them consider leaving the profession. This was higher among minority ethnic group staff (54 per cent) than among white staff (42 per cent) (Borneo *et al* 2020).

A Royal College of Midwives (RCM) survey of 2,000 midwives showed that 66 per cent had considered leaving the profession entirely in the previous six months. The main reasons were dissatisfaction with staffing levels (60 per cent), being unable to provide the quality of care required (52 per cent), high workload (46 per cent), and poor working conditions (37 per cent) (Royal College of Midwives 2016). A Nursing and Midwifery Council survey confirmed the pattern of these findings, indicating that among the most common reasons for intending to quit midwifery were working conditions such as staffing and workload (44 per cent) and disillusionment with the quality of care provided to patients (27 per cent) (Nursing and Midwifery Council 2017).

In adult social care in England, recent analysis by Skills for Care suggests that the turnover of staff in 2019 was 30.8 per cent (around 440,000 leavers per year) (Skills for Care 2020). According to the analysis, there are an estimated 36,000 registered nurse jobs in the adult social care sector in England. Most of these jobs were in care homes in the independent sector (33,000) and

around 1,600 were employed by independent sector non-residential care providers. Registered nurses were one of the only job roles in adult social care to see a significant decrease (15,500, or 30 per cent) since 2012/13 (Skills for Care 2020).

Stress levels

Drawing on the annual Labour Force Survey covering the whole of the UK, the Health and Safety Executive (2019) has shown that health and care staff consistently report higher rates of work-related stress, depression and anxiety than those in most other sectors. National staff survey findings in England, Northern Ireland and Wales indicate that each year, between 34 per cent and 44 per cent of staff report being unwell due to work stress during the previous year (NHS England 2020a; Gov.wales 2018; Department of Health 2016). Such stress is likely to be chronic, as measures of work stress repeated over time among health and care staff are highly consistent (West and Coia 2019).

The UK-wide RCN 2019 employment survey asked respondents to react to the statement 'I feel I am under too much pressure'. Across all sectors, high proportions of the 8,307 nurse and midwife respondents agreed with the statement, with the highest proportions among nursing staff at NHS trusts/boards (66.1 per cent) followed by the independent care sector (63.5 per cent) and general practice (54.2 per cent) – and the lowest proportion (hospices) was still at nearly half (46.2 per cent) (Royal College of Nursing 2019). A further UK-wide survey conducted by the RCN in 2020 revealed that more than half of respondents were concerned about their physical and mental health and 9 out of 10 were concerned about the wellbeing of those in the profession generally (Borneo *et al* 2020).

Before the Covid-19 pandemic, sickness absence (a key human indicator of organisational performance) in the NHS in England (3.4 per cent) was twice the rate in the private sector (1.7 per cent) (Office for National Statistics 2018). It was even higher in Northern Ireland (5.3 per cent), Scotland (5.3 per cent), and Wales (5.6 per cent) (NHS National Services Scotland, Information Services Division 2019; Welsh Government 2019; Committee for Finance and Personnel 2015). We do not know whether one of the consequences of the pandemic will be a large increase in staff sickness absence, but we consider it likely given the prolonged stresses nurses and midwives have experienced – on top of their already high levels of stress.

In the 2019 English NHS Staff Survey, which covers secondary care, of the 187,000 nurses and midwives who responded, some 44 per cent indicated that they had been unwell as a result of work-related stress in the previous 12 months (see 'NHS Staff Survey 2019 in England: variations in indicators of stress across occupational groups and types of organisation', below). This is the highest percentage reporting this in the past five years. More than half reported attending work in the past three months despite not feeling well enough to perform their duties (NHS England 2020a).

Staff stress, absenteeism, presenteeism (attending work despite being unwell), turnover and intentions to quit had reached alarmingly high levels in the NHS in late 2019. And then the pandemic struck.

NHS Staff Survey 2019 in England: variations in indicators of stress across occupational groups and types of organisation

The number of respondents to the 2019 NHS Staff Survey in England (147,350 nurses and midwives and around 40,000 nursing and healthcare assistants) permits a detailed analysis of variation among sub-groups (NHS England 2020a).

The most likely group to report feeling unwell as a result of work stress were midwives (51.9 per cent), followed by health visitors (47 per cent), mental health nurses (46.8 per cent) and district and community nurses (45.9 per cent). Midwives were more likely than any other occupational group in the NHS, including ambulance staff, to report work-related stress. The least likely group – nursing and healthcare assistants (40 per cent) – still had higher levels of stress than medical and dental staff (38 per cent). The results make clear that there are high levels of stress across virtually all staff groups in the NHS, but particularly among nurses and midwives.

Another survey question asks whether staff have come to work despite not feeling well enough to perform their duties in the past three months, a key indicator of presenteeism. The group most likely to do so was midwives (63.7 per cent), followed closely by nursing and healthcare assistants (61.5 per cent), district and community nurses (61.4 per cent) and mental health nurses (61.3 per cent). The group least likely to do so was learning disability nurses (at 54.8 per cent), meaning that within all groups, more than half of respondents reported presenteeism.

Chronic excessive workload is a major cause of staff stress. The survey asks staff whether they have unrealistic time pressures. The proportions of staff answering that they did were extremely high in all groups, ranging from 91.1 per cent of midwives to 72.2 per cent of nursing auxiliaries, healthcare assistants and nursing assistants.

The survey data also permitted a comparison based on the types of organisations nurses and midwives worked in. This revealed some minor variation. For example, the organisations with the highest proportion of respondents reporting feeling unwell as a result of work-related stress were mental health/learning disability organisations (47.2 per cent), and those with the lowest proportion were acute specialist organisations (41.2 per cent) (apart from ambulance trusts, response numbers for which are too low to be reliable).

Causes of workplace stress for nurses and midwives

Being constantly run off my feet, stressed with high caseloads, working all hours, bringing work home, lack of encouragement and being fearful of missing something, not being able to do a good job... figured more or less constantly in my work.

(Recently retired nurse and midwife, interview)

There are many causes of workplace stress in the working lives of nurses and midwives, several of which are examined in more detail in subsequent sections. Here we briefly review seven key factors: work pressure; moral distress; pay; education and entry into nursing and midwifery; work schedules; discrimination; and bullying, harassment and abuse.

Work pressure

The RCN employment survey 2019 shows the excessive levels of work pressure faced by nurses and midwives across all sectors, despite considerable variation by sector: 66.1 per cent of respondents working in NHS trusts/boards felt they were under too much pressure at work, compared with 63.5 per cent of those working in independent sector care homes. In primary care, the comparable figure was 54.2 per cent, and in independent sector hospitals, it was 47.6 per cent (Royal College of Nursing 2019). Levels of demand were already at their highest in a decade even before the Covid-19 pandemic.

An RCN survey conducted in 2020 showed that 4 in 10 respondents said staffing levels had worsened during the pandemic, and this was particularly problematic in the independent and social care sectors. Nearly two-thirds (62 per cent) indicated that patient needs had become more complex during the pandemic (Borneo *et al* 2020).

Midwives are under unsustainable pressure and this has been increasing over time. The RCM stated in 2017 that midwife shortages, rising levels of complexity in pregnancy, and financial constraints in the NHS were increasing demands on England's maternity workforce and services (Royal College of Midwives 2017). The report notes that complexity has increased, with the women now using maternity care typically older and with more underlying health conditions than in the past. There was a reported shortage of 3,500 midwives in England. A 2016 RCM UK-wide survey of those who had left midwifery in the preceding two years or who were intending to leave in the next two years found three key causes: lack of staffing, size of workload, and not having enough time to provide high-quality and safe care (Royal College of Midwives 2016).

The Nursing and Midwifery Council surveyed 1,626 of the 15,600 nurses who left their register across the UK between November 2018 and June 2019 (Nursing and Midwifery Council 2020a). As in previous years, the top three reasons for leaving were retirement (52.7 per cent), too much pressure resulting in stress and poor mental health (26.4 per cent), and a change in personal circumstances (24.5 per cent). Other reasons included disillusionment with the quality of care provided to patients (16 per cent), staffing levels (15 per cent) and concerns about workload (12 per cent).

Moral distress

I put added stress on myself by beating myself up about the fact that could I have done something about it. That was the overwhelming feeling – what could I have done differently.
(Midwife, Sheen *et al* 2016)

... walking back into that room with that dead baby in my arms and telling the parents [...] that was just the worse thing I've truly ever done. And that woman's scream will live with me forever.
(Midwife, Sheen *et al* 2016)

Nursing and midwifery staff are at risk of 'moral distress' in situations where they are prevented from providing the quality of care they feel they should be providing (because of, for example, excessive workload or a lack of resources) (Rushton 2017). Moral distress is associated with higher staff turnover, burnout and dissatisfaction (Brooke *et al* 2018). Being forced to go against their moral compass undermines nurses' and midwives' feelings of integrity, their sense of self-worth as health and care professionals, and their wellbeing. Nurses and midwives told us, during interviews and focus group discussions, that this has been particularly acute during the pandemic when there have been shortages of beds, the need to discharge patients quickly to create capacity, and a shortage of some services for critically ill patients. Added to this, many nurses and midwives also have a pervasive fear of being held responsible for poor care and being accused of negligence (Robertson and Thomson 2016; Duxbury *et al* 2010).

More than two-thirds of nursing staff across the UK working in independent care sector homes (73.1 per cent) and NHS bank staff (66.7 per cent) say they are too busy to provide the level of care they would like. In NHS trusts/boards, the figure is 63.5 per cent and in general practice, 46.6 per cent. Again, though there is much variation across settings, the experience of moral distress among staff is pervasive. It also affects student nurses, with nearly two-thirds (64.4 per cent) saying they are too busy to provide the level of care they would like (Royal College of Nursing 2019).

Pay

Many nurses are dissatisfied with their pay, with 61 per cent of those who responded to an RCN UK-wide survey (7,720 respondents in total) considering their pay/grade to be inappropriate (Marangozov *et al* 2017). Nurses across all pay scales report financial challenges, with more than half (56 per cent) of the 7,720 nurses responding to the 2019 RCN survey saying they had to cut back on food and travel costs, 23 per cent had taken an additional job, 21 per cent struggled to pay their gas and electricity bills, and 11 per cent had been late with mortgage and rent payments. Nursing is a gendered profession and yet research published last year showed that men are still advantaged in terms of pay and opportunities for promotion and development across some pay grades in the UK (Leary *et al* 2019).

Education and entry into nursing and midwifery

According to analysis by the Health Foundation and Nursing Standard, 24 per cent of nursing students and 21 per cent of midwifery students in England are leaving their courses early or suspending their studies. These are nurses and midwives that the health and care system can ill afford to lose (Buchan *et al* 2019a).

We heard from interviewees that entry into nursing and midwifery after training is often highly stressful. Newly registered nurses and midwives can report feeling apprehensive and unprepared, being treated by colleagues as if they were students, and feeling pressured as a result of being continually monitored. They tend to feel they have little autonomy, but face high work demands (Kinman *et al* 2020). Yet they can offer unique and new perspectives on service delivery if their colleagues are open to feedback, learning and the potential of new ways of working.

Work schedules

In England, the figures from the 2019 NHS Staff Survey suggest that 41.7 per cent of registered nurses and midwives work additional paid hours and more than two-thirds work additional unpaid hours (NHS England 2020a). Among nursing and healthcare assistants, the figures are 48.9 and 32.6 per cent respectively. In Northern Ireland, the figures are 53 and 77 per cent respectively (combined data from nurses, midwives and nursing and healthcare assistants) (Department of Health 2016). For midwives in England, the figures are even higher – 46.3 and 79.6 per cent respectively. Many nurses (23 per cent according to the RCN employment survey) do additional bank or agency work in order to top up their earnings (Royal College of Nursing 2019).

Excessive workload and the need to work additional hours are major factors determining levels of work stress (Wall *et al* 1997). Long working hours and shift work have an impact on nurses' and midwives' personal safety, increasing the likelihood of occupational accidents (Johnson *et al* 2018). There is also a significant impact on work/home life balance, which is a powerful cause of stress for nurses and midwives.

Excessive workload affects patient safety, productivity, efficiency, and the mental health and wellbeing of staff. Burnout and poorer wellbeing are associated with poorer quality and safety of care, higher absenteeism, and higher turnover rates (Kinman *et al* 2020). Work periods of more than eight hours carry an increased risk of accidents that accumulates: the risk of an accident is around twice as high after 12 hours of working as it is after 8 hours, imperilling both patients and staff (Salminen 2010). In our interviews and focus groups, we were told that many nurses and midwives prefer to work 12-hour shifts for a variety of reasons, including having more flexibility with days off and being able to work extra shifts. We address the issue of 12-hour shifts in the section on 'Work conditions and working schedules'.

A UK-wide RCN survey of its members conducted in May and June 2020 showed that one-third of respondents were working longer hours than they did before the Covid-19 pandemic. Staff from minority ethnic groups were less likely than white staff to be paid for working additional hours (39 per cent compared to 48 per cent). Some 56 per cent of respondents felt that staff morale had worsened during the pandemic (Borneo *et al* 2020).

Nursing staff from minority ethnic groups are much more likely than other staff to work seven or more additional hours per week and to take on extra paid work (Royal College of Nursing 2019). Interviewees told us that one factor behind this is that these staff are often less able to increase their salaries via promotion.

Discrimination

The evidence on the experience of discrimination at work, particularly among staff from minority ethnic backgrounds, is stark. We review this in more depth throughout the report (see the section on 'Justice and fairness', for example). The 2019 NHS Staff Survey in England showed high levels of discrimination from patients, their relatives or carers in the previous 12 months (18.3 per cent of Black and minority ethnic (BME) staff and 4.6 per cent of white staff reported such discrimination), and from managers/team leaders or colleagues (14.5 per cent among BME staff and 6.4 per cent among white staff) (NHS England 2020a). The proportion of cases of discrimination experienced by BME staff that were based on ethnicity has also risen over the past five years from 77.8 per cent to 82 per cent. Discrimination has substantial influences on workplace stress and physical health (Williams and Mohammed 2008).

Bullying, harassment and abuse

In England, 23.8 per cent of nurses and midwives and 36.8 per cent of nursing and healthcare assistants report having experienced physical violence from patients, their relatives or carers in the previous year, and 40 per cent have been subjected to harassment, bullying or abuse. In addition, more than 20 per cent of nurses, midwives and nursing and healthcare assistants have experienced harassment, bullying or abuse from colleagues in the previous year (NHS England 2020b). In Wales, 20 per cent of staff overall report having been bullied by a colleague or manager in the previous year and 32 per cent by a patient, service user or another member of the public (Gov.wales 2018). In Northern Ireland, the figures are 22 per cent (bullying by staff) and 25 per cent (bullying by patients, members of the public) (Department of Health 2016).

Aside from patients and other members of the public, the main perpetrators of bullying, harassment and abuse are colleagues, and nurses and midwives in a more senior position. Interviewees told us that students and new staff members are particularly likely to report being bullied. Darbyshire *et al* (2019) suggest that bullying and incivility are 'a part of the fabric of almost every nurse's and health professional's lives'. Bullying can cause distress and depression, leading to up to 25 per cent of those bullied leaving their jobs or the profession. Factors contributing to bullying include hierarchical management cultures and nurses and midwives not feeling empowered (Wilson 2016).

Consequences of workplace stress for nurses and midwives

Ensuring that the working conditions of nursing and midwifery staff in primary, secondary, community and social care are supporting them in their work is fundamental to the success of our health and care services. The consequences of failing to ensure nurses' and midwives' wellbeing are profound – for the individuals themselves, their organisations, and the people and communities they serve.

Research reveals that work stressors, when chronic (as they are among health and care workers), are linked to cardiovascular disorders, recurrent cardiovascular disease and hypertension (Schnall *et al* 2017). Other physical outcomes associated with stress include recurring diabetes, musculoskeletal pain, sleep problems, ageing and early mortality. Cognitive and emotional outcomes include negative effects on concentration, depression, anxiety, stress-related addiction and work performance (Roche *et al* 2017). A 2015

meta-analysis on workplace stressors found that high job demands raised the odds of diagnosed illness by 35 per cent and that long work hours increased mortality by almost 20 per cent. Excess job demands, low job control, job insecurity, low social support, long work hours and shift work, as well as unemployment, led to more than 120,000 deaths a year in the US (Schnall *et al* 2017).

The consequences for work are considerable, including low work ability, sickness absence, intention to quit, and early retirement. There are also effects on productivity, performance, engagement, organisational citizenship behaviour (individual behaviour that benefits the organisation and goes beyond assigned tasks and formal reward systems (Organ 1988)) and, inevitably, care quality and patient experience (West and Dawson 2018, 2012).

There is now considerable evidence that stress and strain impair the decision-making and productivity of health and care professionals, and can undermine patient safety (Trzeciak and Mazzairelli 2019; West and Dawson 2018; Firth-Cozens 2001). Previous research has shown that staff attending work while sick are unlikely to be able to perform effectively, while also passing on their illness to colleagues or patients (West and Coia 2019; Mitchell and Vayalumkal 2017). The level of work overload, stress, anxiety and fatigue combine to reduce their cognitive function and increase decision fatigue, thus further endangering their wellbeing and the quality and safety of the care they provide.

A survey of more than 61,000 nurses and 130,000 patients in Europe and the US found that positive work environments (understood in terms of managerial support for nursing, nurse participation in hospital affairs and doctor–nurse relations) and lower ratios of patients to nurses were associated with lower nurse burnout, better care quality, and higher levels of patient satisfaction (Aiken *et al* 2012).

Structure

Our report is structured around a set of three core work needs that must be met in order to ensure the wellbeing and flourishing of people at work: the ABC of core needs. We explore eight key workplace factors that have an impact on the wellbeing, flourishing and work engagement of nursing and midwifery staff, aligned across these three core needs.

In this section, we first introduce the ABC framework that serves as the foundation for the rest of the report. We then outline the structure of the report, including mapping out how the eight key workplace factors and a corresponding set of eight key recommendations fit within the framework.

ABC framework of core work needs

The ABC of core workplace needs are:

- **autonomy** – the need to have control over our work lives, and to be able 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
- **contribution** – the need to experience effectiveness in what we do and deliver valued outcomes, such as high-quality care (Stone *et al* 2009).

Autonomy refers to the need for volition, choice and freedom to organise our experiences for ourselves, and for self-integrity – being able to integrate our behaviour and experiences with our sense of self – for example, as a provider of high-quality and compassionate care (Van den Broeck *et al* 2016).

The need for belonging reflects our desire to feel and to be connected to others – to feel valued, respected and supported in teams and organisations and to care and be cared for in those contexts. The fact that we are at least as likely to die from loneliness as from the effects of obesity or smoking is a powerful indication of the strength and importance of this human need (Holt-Lunstad *et al* 2015). It also captures the importance of working in nurturing cultures and climates that reinforce a sense of relatedness: having a clear, enacted and shared vision focused on (for example) the delivery of high-quality and compassionate care; aligning all efforts around that vision; creating commitment through leadership and management that ensures trust, motivation and positivity; and building effective team and inter-team working. This means ensuring inclusive and compassionate leadership at every level.

The need for contribution reflects a need to make a positive difference through our work as well as to achieve valued outcomes, such as to deliver high-quality care that improves patients' lives. This reflects a deep human motivation to be able to influence our environments for the better. The need for contribution is met, first and foremost, when workloads do not exceed the capacity of staff to deliver valued outcomes. It is also met by ensuring that staff have enabling supervisory support, focused on removing obstacles in the workplace, which creates cultures of learning and accountability rather than directive, controlling cultures focused on blame. And it requires ensuring that nurses and midwives are continuously learning, developing their skills and growing their professional knowledge.

When all three of these needs are met, evidence suggests that people are more intrinsically motivated and engaged and have better health and wellbeing, leading to enhanced performance, persistence and creativity. If any one of these needs is not met, then wellbeing, motivation and performance suffer (Ryan and Deci 2000). An integrated, coherent strategic approach to meeting these needs will powerfully transform the work lives of nurses and midwives, their productivity and effectiveness, and thereby the safety and quality of the care that they lead and deliver.

Structure of the report

The next three sections address each of the three core needs in turn. The chapters are divided into sections, each of which focuses on a key workplace factor that has an impact on the core need under discussion, and on the wellbeing, flourishing and engagement of nursing and midwifery staff. This structure is illustrated in Figure 1.

Figure 1: The ABC framework of nurse and midwife core work needs



For each of the eight factors, we set out the evidence and key issues emerging from our review, illustrate what good practice can look like with examples from across the UK, and outline the changes that are needed to achieve meaningful progress and to support nursing and midwifery staff to flourish and thrive in their work. For each factor, we put forward a single key recommendation alongside a set of more detailed practical steps to be taken to make progress on each recommendation. The recommendations and practical steps are set out in full in Appendix 1.

Implementing the recommendations

Institutions and organisations will only succeed in honouring the ongoing contribution of nurses and midwives if they implement all eight of the key recommendations in this report, rather than adopting only those that seem easiest or most attractive. Transforming the work lives and lived experience of nurses and midwives, and thereby the quality and sustainability of the care they provide, requires that we implement an integrated, coherent and effective strategic approach.

For each and all of the recommendations, health and care organisations should set clear, challenging goals and monitor progress in implementation as a stimulus and resource for supportive development. Systems regulators, improvement bodies and partners in health and social care should work together to help implement the recommendations and should ensure that good practice is shared across the health and care system.

The recommendations are made in relation to the work of nursing and midwifery staff across the UK in the wide variety of settings in which they work. The recommendations are inevitably broad in their reach and it is important that leaders, nurses, midwives and relevant bodies adapt them appropriately to their contexts to ensure effective implementation, fulfilling the spirit and the body of the content.

The recommendations propose that we free nurses and midwives from unnecessary hierarchy and bureaucracy, while at the same time we appeal to the power, influence and authority of national bodies and senior leaders to ensure their implementation. This approach is often referred to within studies of organisations as ‘loose-tight’ leadership (Sagie 1997). To enable innovation among highly skilled and motivated nurses and midwives, it is important to ensure they have the freedom to shape and deliver services in the ways they know are in the best interests of high-quality and compassionate care. At the same time, organisations must ensure that there is clear direction overall, that there are clear goals at every level, and that relevant data is collected to provide information about success in delivering safe and high-quality care. Some initiatives require tight direction from the top while ensuring that their implementation can be intelligently determined by those at the sharp end of the organisation.

The actions that we propose focus on meeting nurses’ and midwives’ core needs by removing stressors in the work environment and by promoting factors that contribute to positive wellbeing and flourishing. Positive emotions, such as compassion, excitement, humour, involvement, joy, love, pride and pleasure, strengthen us (Cameron and Spreitzer 2012). When we have positive feelings, we think more flexibly and creatively and consider more possibilities in our decision-making. That enables us to be more innovative.

There is much work under way at local, regional, national and UK-wide levels seeking to address the issues identified in this report. Some of this work is highlighted and discussed in the following sections. Our recommendations are intended to complement these efforts. Some of our suggestions may seem

basic or obvious. In such cases, it is all the more pressing to seek to understand why they are not currently embedded, widely or universally, and what can be done to ensure that they are.

Government, national bodies and all those who influence the workplaces of nurses and midwives must now commit to creating environments that ensure they are able to provide care to the standards they aspire to and that their health and wellbeing is prioritised. The commitment shown by nurses and midwives, both during the pandemic and throughout their careers, must be honoured by creating workplaces that support, value and respect the work that they do. The aim must be for the NHS and the UK health and care system to provide a model for the world.

2 Autonomy

Autonomy

The need to have control over one's work life, and to be able to act consistently with one's values

The need for autonomy is probably the most important of the three core needs that must be met in the workplace (Van den Broeck *et al* 2016). The key workplace factors identified in this review that have an impact on autonomy are as follows.

- Nurses and midwives feeling they have real **influence** and voice across their organisations and within their teams and departments in relation to decision-making, innovation and their working conditions.
- Nurses and midwives working in **just and fair** workplaces characterised by equity, positive diversity and comprehensive inclusion.
- Nurses and midwives having the right **work conditions** in relation to their physical wellbeing, required resources, time, facilities and sense of the right to and necessity for breaks, and flexible and predictable work schedules and rotas.

This section addresses each of these factors in turn. For each, it sets out the evidence on the current picture and key issues across the UK, and outlines the kinds of changes and interventions that are most urgently needed to ensure that nurses and midwives have meaningful autonomy and control over the way they and their organisations work.

All nursing and midwifery staff should have voice and influence in the genuine co-design of services and the management of their organisations. This requires inclusive leadership that ensures all have such voice and that no groups are relatively disempowered. Nursing and midwifery staff must feel that their organisations are just and equitable places to work. Procedures must be transparent and fair, particularly in relation to recognition, rewards and the management of rotas. And it requires that bullying, harassment and discrimination are eradicated.

Some workplace conditions are fundamental to the sense of control and relate to basic biological needs, such as being able to get a hot drink or nutritious food and having good toilet facilities, or to feeling secure and safe. Autonomy

and the sense of control are also dependent on being able to influence rotas so that other aspects of life and personal responsibilities can be managed.

Authority, empowerment and influence

Evidence from the review

We train people to be autonomous practitioners, then we box them in and strangle them with red tape.

(Emergency care nurse, interview)

Feeling the right and responsibility to lead and influence, helping to shape decisions within a team or organisation, and feeling that your voice, opinions and suggestions are heard and respected are fundamental to our sense of autonomy. These factors also influence our perceptions of being valued, recognised and appreciated.

Nursing and midwifery staff are among the most skilled and motivated members of our national workforces across the UK, yet the research literature and our interviews revealed that many do not feel they have authority or influence at work. Moreover, and paradoxically, nursing and midwifery structures are markedly hierarchical, and linked to pay structures. Why manage a highly skilled and motivated workforce by creating command-and-control environments manifested in multiple layers of hierarchy? The paradox of the nursing hierarchy is reflected in the wider health and care context where, particularly in secondary care, the workforce is structured into multiple layers of hierarchy. The layers of hierarchy and associated bureaucracy and control are likely to reduce the potential for innovation and staff wellbeing and satisfaction (Woods and West 2019).

This report does not explore in detail the role of gender and wider social power imbalances in influencing interprofessional behaviours and hierarchies within nursing, midwifery and the wider health and care system (Clayton-Hathway *et al* 2020). However, this theme emerged from several of our interviews and is touched on at various points in what follows.

Many interviewees shared inspiring examples of innovations initiated by nurses, midwives and their colleagues at scale and pace in response to the Covid-19 pandemic, in an astonishing demonstration of creativity, commitment and courage. A number of stakeholders that we spoke to during this review suggested that what has helped nursing and midwifery staff during this period in some settings is the weakening of command-and-control

structures, rapidly improving communication between nurses and leaders at the centre and devolving responsibility for decision-making.

The challenge for nursing and midwifery leaders and all other leaders is how to help ensure that nursing and midwifery staff have the authority to influence the direction of their work, the strategies and processes of their organisations, and to implement their ideas for new and improved ways of doing things, in psychologically safe and supportive environments. Why? Not least because a review of nearly 600 published articles reveals the strong links between nurse empowerment, satisfaction, retention and patient outcomes (Cicolini *et al* 2014).

To what extent do such environments exist?

The results from recent NHS staff surveys show that slightly more than half of registered nurses and midwives in secondary care settings in England and Wales (57.5 per cent and 57 per cent respectively) report being involved in changes that affect their work areas/teams/departments, and only 60 per cent in England, 57 per cent in Wales and 56 per cent in Northern Ireland say they are able to make improvements happen in their areas of work (NHS England 2020a; Welsh government 2019; Department of Health 2016).¹ These figures suggest that a sizeable minority of staff do not experience voice and influence in a meaningful way and their valuable contributions are being lost. Only 37 per cent in England and 27 per cent in Northern Ireland say that senior managers try to involve staff in important decisions and 35.8 per cent in England and 39 per cent in Northern Ireland say senior managers act on staff feedback (NHS England 2020b; Department of Health 2016). In Scotland, while 71 per cent say they feel involved in decisions relating to their job, only 55 per cent feel involved in decisions relating to their organisation (Scottish Government 2020).

The data from the NHS Staff Survey in England revealed that nurses and midwives who were able to make suggestions to improve the work of their team/department and had frequent opportunities to show initiative had higher levels of work engagement, more satisfaction with their organisation, and

¹ Note that the data across the UK countries is not strictly comparable because nursing assistants were included in the category of nurses and midwives in the HSCNI survey in Northern Ireland and it is unclear how many healthcare assistants were included. Data from the Wales staff survey only included data from registered nurses and midwives. A breakdown by occupational group was not available for the iMatter staff survey in Scotland.

more satisfaction with their immediate work environment (NHS England 2020b). They were less likely to be intending to leave their organisation and much less likely to have been unwell in the previous year as a result of work-related stress (West and Dawson 2012).

Other studies of nurses and midwives have shown that job control is associated with lower levels of burnout (Yoshida and Sandall 2013; Johnson *et al* 2012), anxiety and depression (Mark and Smith 2012), and high levels of work engagement (Brunetto *et al* 2017). Lack of autonomy and low levels of participation in decision-making processes are associated with poorer mental health and wellbeing among nurses (Kinman *et al* 2020).

Good practice

'Structural empowerment' is a key element of the US Magnet recognition scheme, the international accreditation programme for high-quality nursing and midwifery: 'Staff members are developed, directed, and empowered to find the best way to accomplish goals and achieve desired outcomes. Flexibility is encouraged; one size does not fit all' (Luzinski 2012). Structural and psychological authority (or empowerment) in practice mean involving all nursing and midwifery staff through creating decentralised organisational structures. Senior nurses and midwives should also have highly influential roles on the most senior decision-making groups, councils and committees. However, standards of practice and other issues of nursing practice concern are handled in ways that ensure that frontline nurses at all levels exercise influence. For example, point of care nurses should be involved in the development of people policies and programmes that support professional nursing practice, work/life balance, and the delivery of high-quality and compassionate care.

It may seem inefficient to make time for nursing and midwifery staff to meet to discuss and decide on these issues, but we face a crisis in health and care staffing that demands greater involvement of staff in the co-design of solutions. A collective focus is urgently needed on how to promote staff wellbeing and innovation in people management and work processes by using all the knowledge, skills and resources available.

It is not a choice between balancing costs and creating a culture of engagement. We know, for example, that increasing engagement is associated with reduced costs in relation to absenteeism and the costs of paying bank and agency staff (West and Dawson 2018). A culture of nurse and midwife empowerment and influence is the best way to manage our

health and care organisations and to deliver for the communities we serve. They must have the authority to lead, to decide and to innovate – not just as we have seen during the pandemic, but for the new future in health and care.

Hierarchy inhibits voice and influence. The more steps in an organisation's hierarchy, the more difficult it is for those at lower levels to lead and influence (Woods and West 2019). Contributions are often judged by the hierarchical level of the person voicing them. In nursing and midwifery, there can be several layers of hierarchy at the point of care and more at senior level. Many modern organisations (regardless of size) seek to ensure that they have at most three to five layers of hierarchy across the whole organisation in order to reduce the lines of communication and build flatter and more participative structures (Woods and West 2019). This creates the conditions for voice, influence and innovation. The aspiration for nursing and midwifery must be to reduce the number of levels of hierarchy where possible (the same is true of the NHS generally) and replace command-and-control structures and cultures with team and skill-based models.

Shared governance: Nottingham University Hospitals NHS Trust (NUH)

Shared governance moves decision-making closer to the front line and actively involves staff from all pay bands and service areas in improving services and shaping their organisation. It operates through a decentralised leadership structure in which staff share ownership, accountability and decision-making.

NUH has a 'councillor model' structure of shared governance. They have 87 elected councils of frontline nursing and midwifery staff, having begun with a single pilot council in 2012. These include ward-based 'unit practice councils' made up of ward team members, 'speciality councils' representing clinical speciality areas, and 'themed councils' focused on cross-cutting areas, like education and practice development. Each council has around five members, who might be nurses, midwives, allied health professionals, administrative staff or support staff, ranging from bands two to six.

Council members work together on projects that matter to them and their colleagues. Projects cover areas including clinical practice, quality improvement, patient and staff experience, and staff development. They have protected time to meet and to work on their projects. The councils are

self-governing, with training, tools and coaching support from dedicated shared governance facilitators, focused on helping them to work constructively together. Recent projects have included developing a garden area for patients, creating nurse-in-charge identifier stickers, and reducing waiting times by reallocating tasks and lunch breaks in line with patient flow.

The chairs of the councils also meet once per month as a 'leadership council', which is chaired by the chief nurse. This enables them to share lessons and progress with each other and draw on support from the chief nurse to unblock any barriers to their projects. It is also a forum to address wider professional issues and feed into organisational and strategic decisions.

Shared governance is probably the most impactful way of doing things that I have seen in my NHS career. Staff can instigate change and take ownership of their environment and their work, working collaboratively across the organisation, and in doing so they develop confidence and skills.

(Mandie Sunderland, Chief Nurse, NUH)

Advice to others

It's not a set of meetings or a one-off event – it's an organisation-wide culture change. You need buy-in from the board to the front line because it just isn't the usual NHS way. To get that, everyone needs to understand the benefits of liberating frontline staff. So start small, get easy wins, show people how it can work, build momentum.

(Dr Joanne Cooper, Assistant Director of Nursing, NUH)

For more information, see: www.nuh.nhs.uk/nursing-midwifery-shared-governance

Self-managing nursing teams: Buurtzorg, the Netherlands

Buurtzorg Nederland is a not-for-profit social enterprise providing a range of personal, social and clinical long-term care to people in their own homes. It was founded in 2006 with a single team of four nurses. By 2016, there were 850 self-managing teams and 10,000 nursing staff, supported by just 45 administrative staff and 15 regional coaches. It was founded with the aim of connecting to the intrinsic motivation of nurses, who would be the carriers of its vision of high-quality, continually improving and compassionate care.

The Buurtzorg model has two defining features. The first is its holistic approach to care, with one or two staff working with each individual and their informal carers to access all the resources available in their social networks and neighbourhoods to support that individual to be independent.

The model's second key feature is its flat organisational structure and the autonomy held by its nursing staff. Small, non-hierarchical, self-managing teams of nurses and nursing assistants make their own operational and clinical decisions, based on a consensus model of decision-making. The teams are responsible for recruitment, organising and delivering care, and managing their own performance. They are supported by a small centralised back office.

Staff receive training on self-management and the Buurtzorg approach to care. All teams have access to ongoing developmental support from Buurtzorg coaches, whose focus is on enabling teams to learn to work constructively together. There is a strong emphasis on inter-team sharing of innovative practice through the Buurtzorg online platform and regular inter-team events.

Buurtzorg has won 'best employer of the year' in the Netherlands, has achieved the highest service user satisfaction ratings for any community care organisation in the country, and has staff sickness rates that are less than half of those of other community care organisations in the country. The organisation sees trust, flexibility and autonomy as the backbone of its success, set in the context of humanistic, person-centred care.

For more information, see: www.kingsfund.org.uk/blog/2019/09/buurtzorg-model-of-care.

Key recommendation 1: Authority, empowerment and influence

Introduce mechanisms for nursing and midwifery staff to shape the cultures and processes of their organisations and influence decisions about how nursing and midwifery are delivered.

How

- Leaders should ensure that there are effective means to enable nursing and midwifery staff at all levels to shape decisions, policy, practice, work processes and culture in their organisations.
- Leaders should ensure that there are means to evaluate the response to concerns raised by nursing and midwifery staff and ensure a focus on listening, learning and compassion, and not on blame.
- All organisations must work to ensure that the level of voice and influence experienced by staff from minority ethnic groups is equivalent to that of other staff in their organisations.
- The professions should begin a consultation process on how to create flatter structures, better enable teamworking, and encourage an ethos that places greater value on contribution than on hierarchy.

Justice and fairness

People feel more autonomous and in control when they perceive the environments they are in and the way that they and others are treated as being just and fair. Justice is a fundamental value of any human community. Justice is about citizenship, fairness and, above all, leadership (Peterson and Seligman 2004).

This section explores two fundamental and imperative aspects of justice and fairness in the working lives of nursing and midwifery staff: first, that workplaces must be free from all forms of discrimination and injustice; and second, that workplaces must sustain cultures of psychological safety and learning rather than cultures of fear and blame. We examine each of these in turn.

Our report has a particular focus on the experiences of minority ethnic groups within health and care organisations. The issues of justice and fairness apply to all of us of course, and our recommendations are relevant in broad terms to everyone who experiences injustice or negative discrimination because of their demographic characteristics. This includes (among other characteristics) gender, age, religion, disability status, sexuality, and marital status.

We focus on minority ethnic groups here because of the scale of the issue in our health and care services, and the heightened awareness of the issue resulting from the tragic and disproportionate impact of Covid-19 on those in our society, including health and care staff, from minority ethnic group backgrounds. The global Black Lives Matter movement has also demanded urgent and long-needed action to address structural and institutional racism, as well as the pervasive effects of discrimination on the daily lived experiences of people from minority ethnic groups.

Evidence from the review

Racial discrimination

There is indirect racial abuse and blame culture, stopping people going on courses and work promotions even you have enough experience, qualifications and good skills. Because you do not belong to my colour skin and do not speak Queen's English.
(Nurse, Royal College of Nursing 2013)

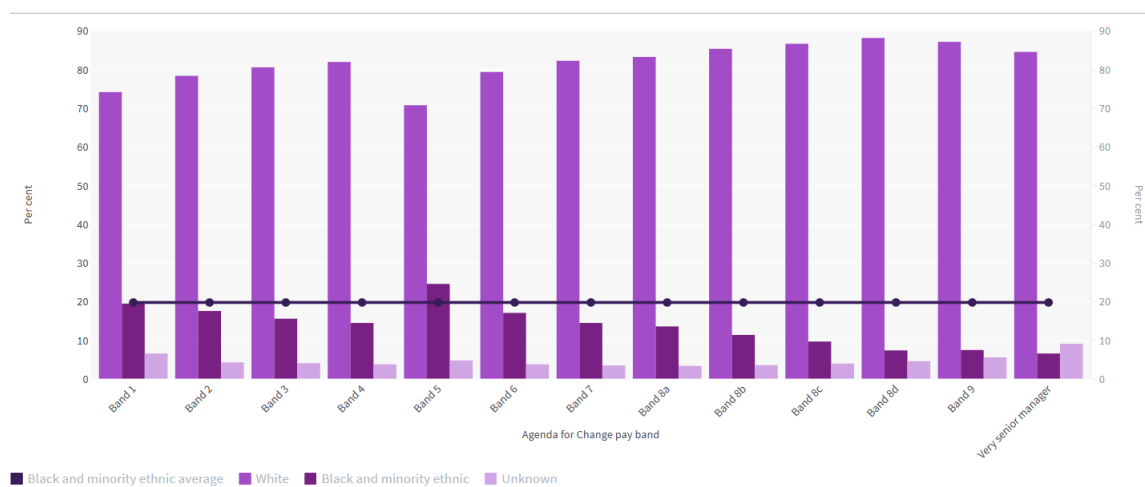
Being treated less well than others based on race or the colour of one's skin is a shocking manifestation of the opposite of justice and fairness. Inclusion is

fundamental to perceptions of organisational justice. It requires leadership that includes rather than excludes all nursing and midwifery staff in decisions about key team and organisational processes. It must be assessed by asking every individual whether they feel included by their leaders to the same extent as others in their team and organisation. This applies in all areas of health and social care (Guillaume *et al* 2014; Cropanzano *et al* 2007).

Discrimination is a pernicious form of exclusion that is demonstrated in the ways that nursing and midwifery staff are recruited, selected, promoted, disciplined and developed.

Minority ethnic group nursing and midwifery staff are systematically over-represented at lower levels of the NHS grade hierarchy and under-represented in senior pay bands. This is reflected in Figure 2, which shows that the proportion of nursing, health visiting and midwifery staff in England from BME backgrounds at bands 8a and above is lower than at bands below 8a, as well as being lower than the proportion of people classified as BME in the English population as a whole. Slightly more than one in five nurses, health visitors and midwives in NHS trusts and clinical commissioning groups (CCGs) in England is from a minority ethnic group background. Although staff from minority ethnic groups constituted slightly more than 20 per cent of nurses in the NHS in England, in 2019 there were only 10 executive directors of nursing (fewer than 5 per cent) from a minority ethnic group background across the 227 NHS trusts in England. In London, 51 per cent of nurses are from a BME background. However, they constitute much higher percentages of staff at lower pay bands and much lower percentages of staff at higher pay bands (NHS England 2020c).

Figure 2: Nursing, health visiting and midwifery staff by Agenda for Change pay bands and ethnicity across NHS trusts and clinical commissioning groups in England: 2019



Source: Workforce Race Equality Standards Team, NHS England

TheKingsFund

In 2019, white applicants in the NHS in England were 1.46 times more likely to be appointed from shortlisting, compared to minority ethnic group applicants. The relative likelihood of minority ethnic group staff entering the formal disciplinary process, compared to white staff, has reduced year on year, from 1.56 in 2016 to 1.22 in 2019, but is still more than 20 per cent higher (NHS England 2020c).

A study of 750,000 staff salaries in NHS England revealed that Black staff, from porters to doctors, are paid less than their white counterparts. On average, Black doctors in the NHS earn £10,000 less a year, and Black nurses earn £2,700 less a year, than their white counterparts. White consultants earn £4,664 more per year than their counterparts from minority ethnic group backgrounds (NHS Digital 2018).

Nursing and midwifery staff are also subjected to racism by colleagues, patients and other members of the public during their work, with obvious negative consequences for their health and wellbeing. The NHS England/Improvement Workforce Race Equality Standard (WRES) provides indicators relating to staff perceptions of discrimination, bullying, harassment and abuse, and on beliefs regarding equal opportunities in the workplace. These have not improved for staff from minority ethnic groups over the past five years. Among minority ethnic group staff in England working in secondary care in 2019, 82 per cent experienced discrimination based on ethnicity (NHS England 2020c). There is an urgent need to change cultures in which

everyday discrimination, described by Alvarez and Juang (2010) as 'subtle, commonplace forms of discrimination, such as being ignored, ridiculed or treated differently', goes unchallenged.

The pandemic has had a shockingly disproportionate impact on health and care staff from minority ethnic groups across the UK. Analysis by *The Guardian* in May 2020 found that, while 1 in 5 UK NHS staff are from minority ethnic backgrounds, this group accounted for 61 per cent of the 200 deaths of staff due to Covid-19 (Marsh and McIntyre 2020). Corresponding with these findings, UK-wide analysis published in *HSJ* in April 2020 showed that staff from minority ethnic groups accounted for 63 per cent of Covid-19 deaths among nursing and support staff, while making up roughly 20 per cent of this staff group (Cook *et al* 2020). We also heard from interviewees that, during the Covid-19 pandemic, international nurses working in the UK with families overseas have faced particular difficulties exacerbated by not having families and support networks to go home to at the end of their working day.

Learning rather than blame cultures

Psychological safety is a 'shared belief held by members of a team that the team is safe for interpersonal risk-taking'. It describes a team climate characterised by inclusivity, interpersonal trust and mutual respect in which people are comfortable being themselves. It involves feeling able to take risks and being able to be vulnerable in front of others, and it provides a space in which differences will be valued and welcomed with curiosity (Edmondson 1999).

There is considerable evidence that psychological safety is vital for effectiveness in health and social care. Environments that create a sense of psychological safety, characterised by a focus on learning rather than blame, increase the pool of nursing knowledge, creative ideas and experience available to decision-makers overseeing health and care organisations (Edmondson and Lei 2014). Such environments also promote nurses' and midwives' engagement, motivation and wellbeing (West *et al* 2017). Compassionate leadership behaviours (attending, understanding, empathising and helping) help to create psychologically safe environments (Edmondson and Harvey 2017).

Many nursing and midwifery staff reported to us that they felt unfairly blamed or threatened by blame. Other barriers that we heard about and have been identified by researchers included the fear of making errors, time pressures,

excessive and often defensive bureaucracy, bullying, rapid change, high workload demands, poor levels of staffing, job insecurity, difficult patients and families, and complex clinical situations. These work environment characteristics increase the risk of burnout, undermine staff wellbeing and performance, and stifle creativity and innovation (Gilbert 2017; de Zulueta 2015; Cole-King and Gilbert 2014).

Good practice

Racial discrimination

Addressing inequalities and inclusion needs to be an ongoing, moment-by-moment activity that engages with and responds to people's lived experiences.

(Ross *et al* 2020)

Organisations must engage staff at all levels in a concerted, inclusive and sustained process to find an approach that works.

Previous research published by NHS England identified five key enablers for addressing race inequalities in both NHS and non-NHS settings (Darling and the WRES Implementation Team 2017):

- clarity around the case for change
- senior leadership support and advocacy
- accountability and responsibility at all levels
- the collection and use of robust, reliable data
- clear, consistent and sustained communications.

Success in addressing race inequality and improving diversity can only be achieved when multi-level strategies, rather than just individual interventions, are implemented over a sustained period of time. Tackling race inequality should be hardwired into corporate objectives and activities, and progress should be tracked continuously as core management information (Guillaume *et al* 2014). Demonstrable leadership and support of these strategies from the board and leadership of all health and care organisations is crucial. However, meaningful progress requires sustained and effective leadership at every level (West *et al* 2015).

Interviewees stressed the importance of establishing that equity, diversity and inclusion are everyone's business, rather than placing the burden of

responsibility on staff holding specific roles relating to diversity and inclusion, or those that are part of minority ethnic group networks. As part of this, all staff should be equipped with an understanding of the evidence on the impact and prevalence of racism and discrimination in the health and care system (Ross *et al* 2020).

Organisations must urgently address the structural inequalities and barriers to career progression experienced by minority ethnic staff, including through changes to appointment and promotion processes, disciplinary procedures and complaints handling, as well as through coaching, mentoring and development opportunities (see 'Equity, inclusion and positive diversity: North East London NHS Foundation Trust', below). Research suggests that HR policies alone are not a solution; it is essential that organisations take a strategic approach to creating cultures of inclusion, built around a vision of high-quality, compassionate care and characterised by compassionate, collective leadership (Guillaume *et al* 2017, 2014, 2013). Alongside this, feedback from stakeholders underlined the need for the Nursing and Midwifery Council to develop its understanding and use of the context of fitness-to-practice referrals in order to identify instances where racism or discrimination are a factor.

Intelligent, systematic and comprehensive assessments must be undertaken to understand whether leaders are truly being inclusive. Everyone must take responsibility for creating climates of inclusion and ensuring that everyone understands the evidence on the profound effects of discrimination and exclusion (Williams 2019). Going back to normal should not be an option in relation to the minority ethnic group health and care workforce. The tragedy of the higher numbers of staff from minority ethnic backgrounds who died during the Covid-19 pandemic must rapidly accelerate real change, so that the NHS and all areas of health and social care are the best place to work for everyone.

Below we suggest an example of an integrated intervention strategy in relation to discrimination. This multifaceted approach is based on evidence about staff experience across the NHS and on international research evidence about EDI in the workplace and what works in organisations in relation to developing equity, equality, positive diversity and universal inclusion.

An integrated strategy for addressing discrimination against minority ethnic groups

All health and care organisations should adapt and implement approaches from good practice organisations within and outside health and care services. Elements should include the following.

- Demonstrable leadership of the strategy from the top and at every level continually.
- Leaders fully understanding the ethnic makeup of the organisation and the communities served.
- Actively seeking minority ethnic group talent and enabling their development.
- Reinforcing zero tolerance of inequities, including those relating to race.
- Thoroughly planning, implementing and monitoring interventions.
- Tracking progress continuously (bi-monthly or quarterly).
- Embedding equity, equality and celebration of diversity throughout the organisation.
- Establishing that equity, equality, diversity and inclusion are everyone's business and not just the EDI lead and minority ethnic group network.
- Involving middle managers continually.
- Hardwiring WRES and tackling race inequality into corporate objectives and activities.
- Anti-discrimination training for interviewers.
- Supporting managers when dealing with grievances and disciplinary cases.

Health and care organisations should change cultures through leadership development and teamworking interventions. These must focus on ensuring that positively diverse and universally inclusive behaviours are modelled and practised at every level of the health and care system. This requires all staff to:

- treat those from different backgrounds with greater civility, respect, and compassion

- be familiar with the research evidence on the impact of racism and discrimination on health, life chances and mortality
- have training in how to intervene when they observe discrimination, incivility or racism towards colleagues
- be enabled to be champions of equity, equality, positive diversity and inclusion.

Leaders at every level have an additional role to play. All leaders must:

- provide stretching project and career opportunities for staff from minority ethnic groups while providing good support
- be familiar with the research evidence on how diversity is associated with team and organisational effectiveness and innovation in health and social care.
- work to create fair and just cultures in their teams and organisations
- seek to mentor and coach staff from minority ethnic groups and create opportunities for reverse mentoring.
- assess their performance as inclusive leaders, ensuring all they lead feel included by their leadership
- ensure all nurses and midwives commit to these ways of working together and receive supportive developmental feedback.

These integrated recommendations for culture change are based on a programme involving:

- good practice examples from organisations across sectors (not restricted to health and care)
- international research evidence on managing equality, diversity and inclusion effectively
- consultations with the leads for the NHS Workforce Race Equality Standard in England
- advice from EDI leads across the NHS

For more, see: www.workplaceedi.com

Learning rather than blame cultures

To ensure effective, high-quality, continually improving and compassionate care, we must shape the environment appropriately for health and care staff. Evidence and research into staff experience points to the need to develop and sustain psychologically safe environments. Psychological safety is vital for effectiveness in health and social care and compassionate leadership helps to create psychological safety. It is in teams that either psychological safety or threat and blame are manifested.

Psychological safety in a team refers to everyone feeling included, cared for and valued; a strong sense of interpersonal trust and mutual respect; team members feeling comfortable being themselves; and team members not fearing that they will be ridiculed, humiliated or judged by their colleagues. Working in such teams is vital for health care quality but even minimally psychologically safe teams (that have clear objectives and meet regularly to review performance) also have significantly lower levels of stress than dysfunctional or 'pseudo-teams' in health care. The more staff work in such teams, the lower the levels of stress, errors that could harm staff and patients, staff injuries, harassment, bullying and violence against staff, staff absenteeism and intention to quit (Lyubovnikova *et al* 2015).

Supportive, psychologically safe cultures can be nurtured by leaders behaving with compassion, who reinforce the fundamental altruism and intrinsic motivation of health and care staff (West *et al* 2017). The affective states of leaders influence the general mood of those they lead – a phenomenon known as mood linkage or emotional contagion (Totterdell *et al* 1998; Hatfield *et al* 1992). Research shows that positive leader emotion is associated with more positive affect and psychological safety among employees, enhanced team performance, and higher rates of prosocial behaviours (Cherulnik *et al* 2001; George 1995, 1991). The principles of compassionate, inclusive and collective leadership are set out in the section of the report on 'Culture and leadership'. All health and care staff must receive training in how to work effectively and supportively in teams, a recommendation we set out in full in 'Teamworking' in the next section.

Equity, inclusion and positive diversity: North East London NHS Foundation Trust

North East London NHS Foundation Trust (NELFT), a mental health and community services provider employing 6,000 staff working over 200 sites,

has achieved sustained improvements across all Workforce Race Equality Standard (WRES) indicators from 2016 to 2018.

Equality and inclusion-related issues were discussed by the board, the ethnic minority network (EMN), and at all meetings and levels in the trust, including inductions for new starters. There was a clear message that race inequality was an issue that required the concerted effort of everyone in the trust. The board reviewed and endorsed a strategy to address racial inequality, and each executive board member worked with an EMN strategic ambassador to deliver specific actions for which they were accountable.

The delivery of the strategy was monitored through regular reviews against measurable ambitions at all levels, including: for minority ethnic group representation at band 8c and above to reflect the proportion of minority ethnic group staff in the workforce as a whole; an increase in the number of minority ethnic group executive and non-executive directors; and a reduction in the number of minority ethnic group staff involved in any HR procedures and litigation cases.

Recruitment

Changes were introduced to make recruitment practices fairer and more transparent. The trust trained 80 minority ethnic group staff to be part of diverse interview panels, and minority ethnic group panel members were enabled to overturn interview panel results and escalate them for review. As a result of these changes, the relative likelihood of white applicants being appointed from shortlisting compared to minority ethnic group applicants improved from 3.12 in 2016 to 1.46 in 2018.

Career progression

NELFT invested in training, coaching and better recruitment processes to help minority ethnic group staff develop to their full potential. As part of this, the recruitment policy was updated so that interviews for all band 8a and above posts needed an EMN panel member. The minority ethnic group staff who went through the training and sat on interview panels reported growth in their confidence and ambition, and a demystification of the interview process – particularly for senior posts. Between 2013 and 2017, the percentage of minority ethnic group staff at band 8a and above increased from 18.4 per cent to 29.3 per cent, and the number of staff at band 8c increased from 2 to 32.

Formal disciplinary cases

The trust sought to address the disproportionate representation of minority ethnic group staff in formal disciplinary cases. Alongside a review of policies and practices across the trust, white managers attended mandatory training to help them understand the differences in opportunities and experiences between minority ethnic group and white staff in the NHS. Investigation panel members were also given cultural awareness competency training. The relative likelihood of minority ethnic group staff entering the formal disciplinary process compared to white staff improved from 2.02 in 2016 to 1.18 in 2018.

Reverse mentoring

A key component of the trust's cultural transformation has been built on understanding the lived experiences and stories from minority ethnic group staff. All board members have a reverse mentor from a minority ethnic group background.

NELFT has the highest proportion in London of minority ethnic group staff reporting that the organisation provides equal opportunities for career progression. It also has the second lowest proportion of minority ethnic group staff (and the fourth lowest proportion of white staff) reporting discrimination, harassment and bullying from colleagues.

For more information, see: www.england.nhs.uk/wp-content/uploads/2019/11/nelft-case-study.pdf

Creating just cultures: Mersey Care NHS Foundation Trust

The Just and Learning Culture at Mersey Care NHS Foundation Trust was built on a restorative practice approach, which recognised that in an untoward incident, caregivers are usually victims too. This shift in organisational culture came after staff voiced their concerns at unfair and distressing processes for managing adverse incidents.

In 2016, Mersey Care engaged with staff to understand staff perceptions and found that feelings of fear, being blamed, shamed or even dismissed worried many. The processes in place were positioned towards mistakes and blame, and in many cases resulted in suspensions. Amanda Oates,

Mersey Care Executive Director of Workforce, said: 'I cried when I heard firsthand about the impact of the consequences that my organisation had had on people's lives.'

Driven to rebuild their relationship with their staff, Mersey Care used the work of Professor Sidney Dekker to change their culture. They adopted the basic position that people generally do not cause harm to others on purpose. They now deal with adverse incidents quickly and informally to reduce the impact of lengthy investigations on staff wellbeing. Disciplinary interventions have also been dramatically reduced. The focus has been shifted from a blame culture to a learning culture, with leaders better able to admit when they have got things wrong. The trust has also introduced support for staff in difficult circumstances, especially those involved in adverse incidents.

After developing and piloting its approach in collaboration with staff, the trust formally introduced its Just and Learning Culture into the organisation in 2017. This created an environment in which staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. The approach involves all those who have a stake in a specific adverse event working together with a focus on three core questions: who is hurt? What do they need? And whose obligation is it to meet those needs?

The trust has also supported staff psychological safety by developing a 'civility and respect' workstream, which emphasises the role of the bystander, raises awareness of the impact of bullying and encourages people to speak up. It set three objectives in the first year:

- *72-hour reviews* – share a copy of incident 72-hour reports with all members of the relevant teams within a week of it occurring
- *share good practice stories* – publish good practice stories every month to learn from things that went well and from those that did not
- *improve support for employees* – publish quarterly data on the trust website to transparently demonstrate whether staff felt supported when things have not gone as expected.

The implementation of restorative practice was followed by a reduction in staff absenteeism, staff turnover, suspensions and disciplinary actions, as well as improvements in incident reporting and in employees seeking

support for workplace issues. There has been a 75 per cent reduction in disciplinary investigations and a 92 per cent reduction in suspensions since 2016. The trust estimated savings of £2.5 million due to higher productivity, reduced back-fill costs due to staff suspensions, reduced time to investigate, and reduced legal and termination costs.

For more information, see: www.matec-conferences.org/articles/matecconf/pdf/2019/22/matecconf_icsc_eswc2018_01007.pdf

Key recommendation 2: Justice and fairness

Nurture and sustain just, fair and psychologically safe cultures and ensure equity, proactive and positive approaches to diversity and universal inclusion.

How

- Health and care leaders must continue to review and reform, as appropriate, structures and processes such as appointment and promotion processes, disciplinary procedures, and complaints handling.
- Health and care organisations should implement a strategic approach for achieving culture change in relation to the experience of minority ethnic group staff. Equity of experience for staff from minority ethnic groups must be achieved in relation to each of the eight broad recommendations in this report.
- Health and care cultures must be changed through leadership development and teamworking interventions so that everyday discrimination does not go unchallenged. The overall aim must be to ensure that positively diverse and universally inclusive behaviours are modelled and practised at every level of the health and care system.
- All health and care leaders must work to create cultures characterised by psychological safety, with a focus on learning rather than blame, thereby increasing the pool of nursing and midwifery knowledge, creative ideas and experience available to decision-makers overseeing health and care organisations.

Work conditions and working schedules

Evidence from the review

Work conditions

Proper breakrooms do wonders for morale. We didn't have a breakroom until recently so there was nowhere to eat. How did we get to a situation where it's being celebrated that staff are being given proper facilities or a breakroom?

(Midwife, focus group)

Many workplace environments are not designed to make best use of the skills of nursing and midwifery staff or to protect their health and wellbeing. In some places, poor practice has become the norm and there are many examples of minor chronic frustrations multiplying and frustrating nursing and midwifery staff.

Nursing and midwifery staff in our interviews often reported poor basic facilities such as access to toilets when needed, availability of nutritious food and hot drinks, access to water, and the ability to take proper breaks for such things. Many work 12-hour night shifts and the absence of basic facilities can sap one's physical and cognitive resilience. Some raised the issue of having a place to sleep before driving home after night shifts. Though most leaders are aware of the impact of night working and the risks from fatigue – both to patient and staff safety from errors – many hospitals do not have rest facilities for nursing and midwifery staff.

A frequent complaint from some nursing and midwifery staff we spoke with was not having lockers to put their valuables in and, in some cases, even when they did, the lockers did not work properly. Staff toilets are sometimes inaccessible or inadequate. With the loss of staff canteens in some hospital settings, those staff who can take time for a hot meal may have to contend with busy lifts on their way to the main hospital public restaurant.

Almost all staff we spoke to valued having a space to meet, share tea/coffee/lunch and relax during breaks. When staff have a social space to come together, to reflect and decompress, they get valuable peer support and time to reflect (Health Education England 2019). There is also evidence that spending time together in this way improves quality of care (Ham 2016). The decision by the Department of Health in England to provide funding for doctors' rest rooms is welcome but raises the question of why such facilities should not be available to all staff in all health and care settings.

During the Covid-19 crisis many health and social care organisations have increased support for their staff, not just by showing appreciation, but by ensuring that basic work conditions were improved. This has included access to food and water 24 hours a day, accommodation in or near the hospital/care home, free parking, and space for staff to take a break when they need it. There has been recognition that when you are exhausted or distressed at work, it is right that there is somewhere (and someone) you can go to and take some time to recover. Some organisations created 'wobble rooms' where staff could go for rest and support when they were distressed. Some staff have been able to work more flexibly, and some organisations have made better use of e-rostering in the interests of staff rather than just efficiency and productivity (see 'A mutual aid approach to flexible staffing during the pandemic: NHS Lothian', below).

The efforts to make the UK health and care system a better place to work during the pandemic must be continued, not least to improve staff wellbeing and retention. *HSJ* recently reported that in some trusts in London, free food provision has been stopped and wellbeing hubs closed (Collins 2020). The *HSJ* article pointed out that the creation of rest hubs, with tea and coffee, was a simple improvement that made a big difference to staff. Other trusts, however, are continuing to provide free parking, hot drinks, investment in staff rooms, mentoring and virtual exercise (see 'Spaces and culture for proper breaks: #WeCARE Café, Kettering General Hospital', below).

Often we're seen as martyrs or heroes. Martyrs just get on with, they don't complain. The culture is that you suck it up and don't have a break, or you're made to feel like you can't hack it. There's a sense that you will just do whatever is asked of you because the patient needs that support.

(Children's nurse, focus group)

A central issue relates to organisational culture: nursing and midwifery staff tend to miss their breaks because of feelings of guilt, responsibility to colleagues or a sense that they are being most effective if they skip breaks – a huge danger in the context of chronic excessive workload. This was a recurrent and pressing theme stressed across many of our interviews and focus groups. It is crucial that workplace cultures emphasise rest, self-care and decompression as a key priority and an equitable component of practice. This must be clearly communicated and modelled by leaders at every level.

Nursing and midwifery staff must be able to take breaks – the meagre two 30-minute breaks on a 12-hour shifts are vital. It is notable, however, that

this allocation prevents nurses from attending (for example) one-hour Schwartz Rounds, which have been shown to have a significant influence on improving staff wellbeing (Maben *et al* 2018).

Moreover, there is evidence of the importance of time for community nurses to catch up with each other during breaks (Adams *et al* 2013). A study of two adult community nursing services in England showed the importance of informal work conversations between immediate colleagues for satisfying work relationships and the care of patients. Such catch-ups help to develop a shared ethic of care and professional identity.

When staff do not feel safe, their need for control is not being met. Asking staff to work with potential or confirmed cases of Covid-19 without adequate personal protective equipment (PPE), for example, puts their lives, the lives of their families, and the lives of their patients at risk. The RCN undertook two surveys of health and care staff in relation to PPE during the Covid-19 pandemic. More than 5,000 nurses and midwives across the UK responded, indicating that since April 2020 there were still shortages of essential PPE in all settings, and some health and care staff were reliant on home-made PPE or items being donated. More than a third of respondents felt they were required to care for individuals with Covid-19 without having adequate PPE. This was significantly worse for BAME nursing staff, with more than half (56 per cent) reporting feeling this pressure. Those working in care homes were most likely to report feeling they had to care for individuals with possible or confirmed Covid-19 without adequate protection (41 per cent, compared with 38 per cent in hospitals, and 24 per cent in the community) (Royal College of Nursing 2020b, 2020c).

Another set of risks relate to repetitive strain and musculoskeletal disorders for staff if basic ergonomics are neglected (McCoy and Evans 2005). In the 2019 NHS Staff Survey in England, 35.5 per cent of nursing and healthcare assistants and 31.5 per cent of registered nurses and midwives reported musculoskeletal problems in the previous 12 months as a result of work activities (NHS England 2020b).

Finally, in our interviews we encountered widespread frustration about inadequate information technology (IT) systems that meant nursing and midwifery staff could not provide the care needed because so much of their time was spent battling with the technology – slow systems with out-of-date or dysfunctional software. For example, nursing and midwifery staff talked to

us about having to try multiple passwords until they could log in to a computer, and having computers crash unexpectedly.

All these deficiencies in working conditions create persistent frustrations for hard-pressed nursing and midwifery staff. Nursing and midwifery are demanding and stressful professions, so nursing and midwifery staff need working conditions that provide them with the right basic facilities to practise effectively and provide good-quality care to patients. It is important for employers to understand the unintended consequences of failing to provide basic facilities for staff to do their jobs.

Another way in which the need for control is undermined is being subjected to or threatened with physical assault or with harassment and bullying. In 2019, national staff surveys in the NHS revealed that 23.8 per cent of registered nurses and midwives in England and 26.9 per cent in Northern Ireland reported having been physically assaulted during the previous 12 months (in England, the figures are 31.9 per cent for those working in mental health and learning disability and 11–12 per cent among community nurses; among nursing and healthcare assistants working in mental health and learning disability trusts, the figure is much higher at 56 per cent).

Forty per cent of registered nurses and midwives in England, 32 per cent in Wales and 36 per cent in Northern Ireland report being bullied, harassed or abused by patients, their carers, relatives or other members of the public; 21.6 per cent by colleagues; and 13.6 per cent by managers (NHS England 2020b; Gov.wales 2018; Department of Health 2016). All of this undermines the need for control – and simply to feel safe – and clearly indicates that cultures and work environments must be transformed.

Fatigue, work schedules and rotas

When I get home from work, my eight-year-old son often asks whether I managed to have a break... Always being extremely busy makes it harder to prioritise your own wellbeing.

(Emergency care nurse, Royal College of Nursing 2020a)

I am a single mother of a 12-year-old boy, and he has recently transitioned to secondary school. I cannot remember the last time I finished a shift on time, nor can I remember the last time I finished and had the energy to give my son the positive attention he deserves.

(Nurse, Royal College of Nursing 2017)

Shift work, night work, rotas, unpredictable hours, and long or unsociable hours are key issues that have an impact on nurse and midwife wellbeing. Shift work is known to cause strain to varying degrees, with a high level of sleep disturbance among those on rotating shifts (Folkard and Monk 2016; Smith *et al* 1999; Barton 1994). Fatigue and sleep deprivation, which are associated with working long hours and shift pattern working, affect error rates and quality of care as well as personal safety (West and Coia 2019).

Shift work is generally necessary to ensure 24-hour care. Research shows that shift work has an adverse effect on the health of nurses and midwives, including stress, sleep deprivation, cardiovascular disease, gastrointestinal symptoms, and mental health illnesses (Querstret *et al* 2020; Ball *et al* 2017). In a review of nearly 800 articles on fatigue risk management in health and care, researchers reported on a large-scale longitudinal US study of nurses that showed how working rotating nights shifts for more than five years is associated with all-cause and cardiovascular disease-related mortality (Querstret *et al* 2020). Working night shifts for more than six years is associated with a higher risk of all-cancer mortality. Too little or too much sleep and poorer sleep quality are associated with increased risk of type 2 diabetes. Shift work is associated with poorer sleep quality and duration, increased fatigue, gastrointestinal problems, hormonal imbalance, anxiety and other mood disorders.

Fatigue is also related to accidents, injuries and death in hospital settings because of cognitive impairments. Fatigue is a threat to nurses' personal safety and to patient safety and care. It is associated with higher levels of musculoskeletal injuries, and needlestick injuries. Work schedules are implicated, especially 12-hour shifts and rotating shift patterns. Nurses on 12-hour shifts typically sleep only 5 hours between shifts (instead of the required 7–9 hours a day). Failure to have enough time off between shifts leads to increased medication errors and patient mortality. Working shift patterns that include night shifts increases the likelihood of nodding off while driving home after a night shift (West and Coia 2019). And fatigue affects the ability to show compassion – probably the most powerful intervention in nursing care.

Some nurses and midwives have been in accidents when driving home following a night shift and sadly some have lost their lives. Yet we have known for many years that shorter sleep duration, working at night, and difficulties remaining awake while at work are linked to drowsiness while driving. In a US study of nearly 900 nurses, two-thirds reported at least one

episode of drowsy driving over a four-week period and a small group reported drowsy driving daily (Scott *et al* 2007).

Within nursing there is a protracted debate about whether 8-hour or 12-hour shifts are preferable. Some nursing staff report being able to accomplish more work in longer shifts and improve continuity of care and relationships with patients. Concerns have also been raised that 8-hour shifts could hamper recruitment and retention of nurses (Kinman *et al* 2020).

We were told during this review that it is more expensive to implement 8-hour shifts, and that staff sometimes resist such changes because they would mean fewer days off, which would in turn affect their ability to work extra shifts and thereby earn extra pay. We heard that because there are additional barriers to promotion for some minority ethnic group nurses, doing 12-hour shifts enables them to do additional paid work, thereby enabling them to increase their incomes. Of course, this entails additional costs in terms of their wellbeing and ability to manage other responsibilities easily (such as family and other caring responsibilities).

Although longer shifts are popular with some nurses, they are probably detrimental to their mental health and wellbeing. A survey of 31,627 nurses from 12 European countries (including England) found that nurses working more than 12 hours had a significantly increased risk of burnout (Dall'Ora *et al* 2015). UK studies of nurses and midwives suggested that longer shifts increased the risk of job dissatisfaction and burnout (Ball *et al* 2017; Yoshida and Sandall 2013). Some types of shift work in particular (such as working nights and weekends) and poor rostering have a significant negative impact on nurses' and midwives' mental health (McPherson *et al* 2016; Royal College of Nursing 2013).

International evidence on the effects of long shifts is growing (Pryce 2016). A secondary analysis of data collected in England examined the association between shift length, job satisfaction, scheduling flexibility, care quality, patient safety, and care left undone. In a sample of 31 NHS acute hospital trusts from 401 wards, in 46 acute hospital sites, 74 per cent (1,898) of nurses worked a day shift and 26 per cent (670) a night shift. Self-reported quality of care was higher among nurses working eight hours or less on a shift (15.9 per cent) compared to those working longer hours (20.0 to 21.1 per cent). The odds of poor-quality care were 1.64 times higher for nurses working 12 hours or more. Average 'care left undone' scores were highest among those working 12 or more hours. Job dissatisfaction was also higher

the longer the shift length. Overall, the research suggests that shifts of 12 hours or more are associated with poor ratings of quality of care and higher rates of care left undone (Ball *et al* 2017).

Either shifts must be shorter, or we must discover how 12-hour shifts can be better managed to avoid these negative outcomes. The research literature suggests the need for managers to include implementing quiet time at the workplace, providing a safe space for staff to nap during breaks, facilitating eight-hour shifts, and encouraging a multidisciplinary team approach when managing workload (West and Coia 2019; Ball *et al* 2017; Ruggiero and Redeker 2014).

Lack of access to flexible working was frequently cited as a reason for leaving midwifery. A survey of heads of midwifery in April 2016 showed that 4 in 5 found it difficult to accommodate requests to reduce the number of night shifts and the number of weekend shifts, and 9 in 10 found it difficult to accommodate requests to fix shifts (so, no rotation of shifts). This was almost entirely due to staff shortages and pressure of work (Royal College of Midwives 2017).

Many nurses and midwives feel an obligation to work outside their contracted hours in order to ensure that patients get the care they need. More than two-thirds (67.5 per cent) of registered nurses and midwives in England and 77 per cent in Northern Ireland reported working additional unpaid hours. We know from analyses of data for health and care service staff that those who report working extra unpaid hours have lower levels of engagement, less satisfaction with their organisation, and are more likely to have been unwell as a result of stress at work during the previous year. Even registered nurses and midwives who worked extra paid hours (41.7 per cent in England and 53 per cent in Northern Ireland) are likely to have higher levels of intention to quit than those who do not work extra hours (NHS England 2020b; Department of Health 2016).

Nursing and midwifery staff told us of widespread problems of poor rota design coupled with increased demand. There was a perception that arbitrary rota decisions are made by people who do not understand (or, in some cases, do not care about) the impact that shift work has. This adds to nurses' and midwives' sense of loss of autonomy and leads to anger and resentment. Conflict between work and home life is a widespread problem in health and care, which has an impact on wellbeing (Grant-Vallone and Donaldson 2001).

Those experiencing such conflict are up to 30 times more likely to suffer depression or anxiety (Frone 2000).

A good work–life balance is vital for mental health and wellbeing. The most important protective factor for wellbeing is spending good quality time with people we love and who love us. Only 34 per cent of a sample of 7,720 nurses across the UK felt satisfied with their work–life balance (Marangozov *et al* 2017). Poor work–life balance was a cause of burnout in midwives (Yoshida and Sandall 2013) and of work-related stress and low engagement among hospital nurses in England (Carter and Tourangeau 2012).

Pay

Several interviewees identified pay as a significant factor having an impact on nurse and midwife wellbeing. First, in relation to workload and fatigue, we heard that many nurses work extra hours, extra shifts, and in additional jobs in order to top up their wages, and that the commitment among many nurses and midwives to working 12-hour shifts was in part due to the need to find time to carry out this extra work. This income is often the only or main source of income in their households; for many, it is necessary to ‘top up’ income in this way in order to avoid or mitigate in-work poverty (Royal College of Nursing 2019).

Second, we heard that perceived low pay is a key dissatisfier for nursing and midwifery staff, whose sense of being poorly compensated corrodes their commitment, their engagement, and their sense of being appropriately valued by their organisations. A UK-wide RCN survey of nurses found that 60 per cent of respondents considered their pay/grade to be inappropriate (Royal College of Nursing 2019).

In the context of nursing being a highly gendered profession (90 per cent female), there is still a gender pay disparity and disparity of opportunity for advancement between male and female nurses across some pay bands in the UK (Clayton-Hathway *et al* 2020). Analysis by Leary *et al* (2019) showed that men are over-represented in the more senior nursing jobs across the UK compared to the rest of the UK female nursing population. This research showed that female nurses are also more likely than their male counterparts to accept a demotion or a compromise in pay in a role. The Fawcett Society (2018) has noted that while there is no single cause of the gender pay gap in the UK, ‘important factors include discrimination, undervaluing roles predominantly done by women, dominance of men in best paid positions and

unequal caring responsibilities'. The relationship between the gendered nature of the nursing profession and disparities in pay, status and influence arose as a theme in several of our interviews (for further discussion, see Clayton-Hathway *et al* 2020).

Good practice

Analyses from the English NHS Staff Survey showed that staff satisfaction with work–life balance was linked with better financial performance of trusts/boards, lower staff absenteeism, higher patient satisfaction, and lower risk of infection rates in hospitals (NHS England 2020b). Such findings highlight the need for evidence-informed initiatives to promote work–life balance and recovery from work.

Some aspects of what should reasonably be expected of nurses' and midwives' working environments will vary across sectors and settings. For example, some staff working in community, primary and social care settings might be based in smaller clinics that cannot directly provide access to nutritious food and drink. As with all our recommendations and accounts of good practice, some elements will need to be adapted across different contexts to reflect these differences.

Having good work conditions means having:

- adequate protective equipment for staff to do their jobs safely
- protection from violence, threats of violence, harassment, bullying and abuse – including through appropriately designed buildings and operational processes
- effective IT systems and support with using them
- support for day-to-day work – for example, clean scrubs for nurses working in surgery, and somewhere to change
- time and support for essential tasks, such as preparing for appraisal and revalidations
- break times and comfortable locations to take breaks
- access to bathroom facilities and nutritious food and drink, including during night shifts
- lockers to secure belongings.

The British Medical Association (2018) recently published a Fatigue and Facilities Charter for health and care employers. Many of its recommendations are pertinent to the workplace needs of nursing and midwifery staff. They include the following.

- Use forward-rotating rota designs (day-evening-night) that minimise frequent transitions between day and night shifts.
- Give adequate recovery time after night shifts to re-establish normal sleep patterns – at least 46 hours after completing the final night shift.
- Provide clearly rostered breaks that comply with rest/break entitlements.
- Make all staff aware of the importance of taking their breaks and run regular campaigns to encourage this.
- Help staff to raise issues with missed breaks – for example, through monitoring or exception reporting systems – and create action plans committing the employer to ensure that all breaks are taken.
- Ensure that rosters and staffing numbers are sufficient to allow safe cover if staff are unexpectedly absent – for example, for sickness or compassionate leave.
- Appoint a nominated employer representative for dealing with fatigue and facilities.

Some interviewees recommended that health and care organisations should establish and maintain effective mechanisms for nursing and midwifery staff to report rotas that are not compliant with good practice. Systems regulators, improvement bodies and other partners were seen to have a role in ensuring that employers had good rostering practices in place.

A mutual aid approach to flexible staffing during the pandemic: NHS Lothian

NHS Lothian is the second largest health board in Scotland, providing primary, community and hospital services to around 850,000 people. Early on during the pandemic, it established a 'mutual aid' staff mobilisation arrangement to facilitate the movement of staff across acute, community and care home services. Clinical and non-clinical staff could be re-deployed from areas with lower levels of activity to wherever need was greatest, enabling an agile response to the unpredictable and dynamic situation as it

evolved. The system was co-ordinated by a Covid Nursing Workforce Hub, led by a lead nurse, a nursing recruitment lead and a staff bank manager, working in close partnership with human resources leads.

The arrangement was underpinned by a set of principles emphasising a supportive, collegiate and flexible response with a clear focus on staff wellbeing. Staff remained in regular contact with their line managers and the teams they were re-deployed from. All re-deployments were voluntary and the hub team sought to enable people to work at locations closer to their homes.

The e-rostering system was used to facilitate shift-swapping, track staff deployment and ensure that annual leave remained aligned to individuals, making the movement of staff across the organisation more flexible and less bureaucratic. Additional hours and overtime were captured in real time and this generated automatic alerts to charge nurses and clinical nurse managers when services were pressurised and staff were going above and beyond. E-rostering also allowed the board to ensure that staff did not have persistently excessive working hours and that sufficient rest was rostered in line with Working Time Regulations and Scottish government guidance around ensuring staff wellbeing.

Advice to others

Having a central hub with a formal process (including a request form) for accessing mutual aid was crucial in enabling effective co-ordination. It was also important for us to be clear that there needed to be an exit strategy for the services that received mutual aid.
(Fiona Ireland, Deputy Director of Nursing, NHS Lothian)

Access to food during out-of-hours shifts: the Royal Free London NHS Foundation Trust

During a trust-wide programme to improve staff wellbeing, a staff survey at the Royal Free revealed that while 87 per cent of staff agreed that hot food was important to their wellbeing, only 7 per cent had been able to buy hot food at night – at any of the hospitals they had worked in. The trust worked with its catering service to set up a scheme through which staff could buy vouchers for hot meals that were delivered by hospital porters. Staff choose meals from the same catering menu as patients, giving them access to healthy and balanced meal choices. The trust reports that staff have responded well and feels that this change has improved their wellbeing at work.

For more information, see: www.nhsemployers.org/blog/2019/12/improving-night-workers-nutritional-wellbeing

Tackling dehydration: James Paget University Hospitals NHS Foundation Trust

The James Paget University Hospitals NHS Foundation Trust launched the Think 2 Drink initiative in 2019. Jincy Bilgy, an emergency nurse who spearheaded the initiative, noticed that 'we always offer patients a drink, but often we don't think about it ourselves. Some staff were also under the misapprehension that they couldn't drink water at work, but that's just not true. We know that dehydration can really impact someone's health.' They set up hydration stations on every ward and department, and gave all their staff a free re-usable water bottle with space to write their name. The bottles can be stored at the stations, making them easy to grab during busy shifts.

For more information, see: www.rcn.org.uk/healthy-workplace/healthy-workplaces/health-and-safety/rest-rehydrate-refuel

Spaces and culture for proper breaks: #WeCARE Café, Kettering General Hospital

The #WeCARE Café and garden was set up as a space for staff to take a break away from the wards. It was intended as a place to decompress, socialise, offer peer support and to have access to 'listeners' who could signpost to other sources of support where needed. Initially supported by local community donations alongside investment by the trust, the supplies

are now funded by the trust with a plan to maintain the space on an ongoing basis.

During its first month, more than 4,000 staff accessed the space. The trust encouraged a culture of break-taking through regular messages and team briefs emphasising the importance of pausing and resting properly, and by supporting wards to find ways to release people for time out in the café. The infection control team worked to make the café a 'Covid-safe' area, where no personal protective equipment (PPE) would be needed. According to the trust, the café's relaxed, non-clinical setting proved to be a useful place for managers and teams to meet with staff members coming back into work after shielding, in order to help support them through this transition.

Advice to others

The community want to help out, so give them an easy way to do so. And make sure you invest and do it properly, then you'll see a wide range of benefits for staff and for patients.

(Leanne Hackshall, Director of Nursing and Quality, Kettering General Hospital Foundation Trust)

Key recommendation 3: Work conditions and working schedules

Introduce minimum standards for facilities and working conditions for nursing and midwifery staff in all health and care organisations.

How

- All health and care employers should provide all nursing and midwifery staff with places, time, and a sense of the right and necessity to rest and, where appropriate, sleep. In appropriate settings, employers should ensure access to bathroom facilities and nourishing food and drinks (including basic hydration).
- Pay is a dissatisfier for nurses and midwives, given their expertise, contribution and commitment. They must be appropriately remunerated for their work.
- All health and social care organisations must take effective measures to protect nursing and midwifery staff from violence, threats of violence, harassment, bullying and abuse.

- Nursing and midwifery leadership, national bodies and leaders of every organisation employing nursing and midwifery staff should review facilities and produce guidance for nursing and midwifery staff to ensure compliance with wise, evidence-based management of fatigue and facilities.
- All employers should implement work schedules and rotas based on realistic forecasting that supports safe shift swapping, enables breaks, takes account of fatigue, and involves nursing and midwifery staff with knowledge of the specialty to consider the demands that will be placed on them.
- Assessments should be regularly undertaken to ensure that staff from minority ethnic groups are not disadvantaged relative to other staff in relation to working conditions.
- The nursing and midwifery professions should undertake a courageous, comprehensive and transparent joint review of the impact of 12-hour shifts on their mental health and wellbeing, on capacity for earnings, and on care quality and safety. The review should investigate the full range of alternatives such as the use of hybrid shift systems. The review should also explore how to mitigate any negative impacts of the current system of 12-hour shifts on staff wellbeing and care quality and safety.

3 Belonging

Belonging

The need to be connected to, cared for by, and caring of colleagues, and to feel valued, respected and supported

The need for belonging reflects our desire to feel and be connected to others – to feel included, valued, respected and supported in teams and organisations and to care and be cared for in those contexts. There is abundant evidence to show that support from colleagues enables people to thrive in their work, helps them to cope with difficult work experiences, and buffers them from the wider organisational factors that cause irritation and stress (Bliese *et al* 2017). Exclusion, discrimination, bullying, incivility and chronic conflict have the opposite effect. The support of nursing and midwifery colleagues for each other has been movingly evident during the pandemic. It has enabled many nurses and midwives to cope successfully in very challenging conditions.

To create the conditions that enable nursing and midwifery staff to deliver high-quality care, flourish and stay well, all must work together to create positive, supportive, compassionate, inclusive and cohesive communities in the workplace. Belonging requires an organisational commitment to the delivery of high-quality and compassionate care that reinforces nurses' and midwives' sense of vocation. One consequence of the pandemic highlighted by interviewees and focus group participants was the pride many nurses and midwives have felt about what they do, augmented by the powerful emotional support towards them that has been felt and demonstrated by citizens across the UK.

This section focuses, first, on **teamworking**. The quality of teamworking, and the culture, inclusiveness and supportiveness of teams, are central to nurses' and midwives' sense of belonging. We examine how positive teamworking can be nurtured and sustained, including through role clarity and stability, and how having a shared sense of purpose and shared objectives (one of which is team member wellbeing) is crucial.

The second part of this section explores **culture and leadership**. Belonging is nurtured by inclusive leadership and management behaviours that demonstrate trust and model compassion, as opposed to focusing on control and maximising productivity. We set out the principles of collective,

compassionate and inclusive leadership, and show how these can be developed to foster cultures of high-quality, continually improving and compassionate care and support, both for patients and for staff.

Teamworking

Evidence from the review

An effective team is a group of usually no more than 8–10 staff, who work together to achieve a limited number (5–6) of clear, shared objectives. The team is provided with data or information that ensures helpful feedback in relation to their progress in achieving their objectives. Team members are clear about their roles in the team. The team climate is characterised by positive emotions and a sense of psychological safety. Where there are larger numbers of team members (as is typical on wards), it is more difficult to manage team processes and communication, and so clear protocols are required (West and Markiewicz 2016).

Teams with these characteristics ensure greater role clarity for team members, provide higher levels of social support, and buffer members from the negative and depleting effects of wider organisational demands. Good team leadership also ensures connection and compassion across boundaries so that health care staff work together across professions to deliver high-quality care (West and Lyubovnikova 2012; West 2012).

In modern health and care services, the skills of 'teaming' that enable people to work in multiple teams or with a variety of team members who may be different across shifts are vital, but it is also necessary for wellbeing and effectiveness to have stable membership of a home team. Dropping in and out of teams or rarely being part of a team with the same team members undermines their sense of connection, community and belonging (West 2012).

Working in teams is vital for health and care quality but there is also good evidence that those working in supportive teams, with good team leadership, have significantly lower levels of stress than dysfunctional or pseudo teams in health and care. The more members of staff working in such teams in a health and care organisation, the lower the levels of stress, errors, injuries, harassment, bullying and violence against staff, staff absenteeism and (in the acute sector) patient mortality; and the higher the levels of patient satisfaction (Lyubovnikova *et al* 2015).

Teamworking in health and social care can easily be assumed to be functioning adequately and taken for granted, with blithe reflections such as 'we are all one big team here'. But we know that the quality of teamworking and inter-teamworking in health and care in the UK is often poor (West and Markiewicz 2016; West and Lyubovnikova 2013). The basic mechanisms of effective teamworking are often not in place in our health and care organisations, even though there is extensive international research that consistently identifies what is required to have effective teams in health and care.

Data from the NHS national staff surveys across the UK suggests that in the acute sector, only around 40 per cent of staff work in what might be called real teams (NHS England 2020b). These are teams that fulfil the very minimum of requirements of having clear, shared objectives and meeting regularly to review performance and how it can be improved (Lyubovnikova *et al* 2015). The data from staff surveys across the four UK countries suggests that between 50 per cent and 60 per cent of nurses and midwives work in 'pseudo teams' in health and care, which either do not have clear, shared objectives or which do not meet regularly to review performance and how it can be improved.

The more staff in hospitals who work in real teams, the better the mental health of staff, the higher their levels of engagement, patient satisfaction, care quality and safety, and the lower the levels of staff intention to quit and of patient mortality (Lyubovnikova *et al* 2015). Data from primary care over many years has shown that quality of teamwork determines care quality and staff wellbeing (West and Markiewicz 2016).

Effective teams have climates of psychological safety, shared team leadership, take time to review and improve, and work co-operatively across boundaries with other teams and departments (Edmondson and Lei 2014). Psychological safety in a team refers to: everyone feeling included, cared for and valued; a strong sense of interpersonal trust and mutual respect; team members feeling comfortable being themselves; and team members not fearing they will be ridiculed, humiliated or judged by their colleagues.

Shared leadership in effective teams is characterised by valuing all contributions regardless of profession or place in the status hierarchy. Shared leadership ensures that leadership moves between individuals (even though there may be a hierarchical leader) dependent on expertise in relation to tasks rather than hierarchical position (West *et al* 2014). Effective nurse and

midwifery team leadership ensures that there is regular, protected time for collective reviews of team functioning and performance.

Inter-team working is as important as quality of intra-team working in the delivery of health and social care. Effective teamwork involves co-operating and supporting other teams to ensure effective delivery of high-quality and compassionate care overall, rather than just the team's own area of responsibility (Lyubovnikova *et al* 2015).

These elements of effective teamwork apply in primary care, secondary care, community care and social care. There is much to be done in these settings to ensure that nurses, midwives and other health and care staff work in effective teams. Training in the basic skills of teamworking and team leadership is required at all levels. There is compelling evidence of the value of team training for health and care professionals, showing that it is effective for both students and practising clinicians (Hughes *et al* 2016). Moreover, high-fidelity, expensive team training appears to be no more effective than low-fidelity, inexpensive team training.

The evidence suggests we must find new ways to enable nursing and midwifery staff to work as part of effective and supportive (ideally multidisciplinary) 'home' teams. This will be challenging, but nurse leaders and other senior leaders and managers who respond positively to this challenge can make a profound difference to nurses' and midwives' wellbeing, as well as to productivity and care quality.

In our interviews, we heard that during the pandemic, some teams have become stable entities, so staff have felt more part of a 'home team'. Camaraderie, daily briefings, huddles and regular time to discuss patients has dramatically improved teamwork. Some teams have had a clear sense of purpose and have built cohesion and a sense of team compassion and support. Check-ins and huddles, with the whole team having protected time to have lunch/coffee breaks together, have helped build belonging, cohesion and support.

Switching off telephones at lunch and going out for lunch together – initially this was shocking. But the positive outcomes were incredible, and everyone was so well rested. The leader in the team absolutely made sure this happened. It's not all about the patient, it's about the staff too. But if you look after your nurses and midwives, the patients

will benefit.

(Nurse, focus group)

Interviewees described how during the pandemic, there has been an extraordinary acceleration of more integrated ways of working in health and social care in some settings, with a significant improvement in the quality of inter-team working across boundaries. We heard how nurses and midwives have led the way in overcoming communication challenges, adapting and developing new roles, and breaking down barriers to work across primary, secondary and social care.

Improved teamwork is just one of the outcomes identified by interviewees of the blurring of hierarchical and professional boundaries – a contrast to operating in silos. We also heard about improvements in inter-team and system co-operation. Organisational identities have been relinquished as staff have transferred from acute settings to work in social care when necessary. And cross-boundary working has become the new normal in some areas with collaboration between primary care, secondary care and social care and a range of volunteer and community groups. Ways of working have been transformed in a matter of days and in ways that were unimaginable just a few months previously.

Good practice

Good practice would see all nursing students, nurses and midwives belonging to a stable 'home team' (where possible, multidisciplinary) that enables:

- involvement in quality improvement initiatives
- a sense of belonging and social support
- a space to discuss challenges, difficulties and frustrations
- opportunity for appreciation and recognition
- clarification of roles and responsibilities
- peer coaching and mentoring
- professional development
- leadership development and teamwork training.

When diverse professional groups (such as general practitioners, health visitors, district nurses, midwives, physiotherapists, pharmacists, counsellors and practice nurses within primary health care teams, and psychiatrists, social

workers, occupational therapists, psychologists and community psychiatric nurses in community mental health teams) work well together, alternative and competing perspectives are carefully discussed, leading to better-quality decisions about patient care. Primary health care teams that include many different professional groups, for example, have been shown to deliver higher-quality patient care and implement more innovations in patient care (Borrill *et al* 2000).

Face-to-face multidisciplinary team (MDT) working should be the first choice. Such teams need stability of membership to become cohesive, time for reflection on work challenges, accessible space to meet, and ways of involving all team members. Social interactions such as shared tea/coffee breaks, meals and celebrations also build a sense of cohesion and psychological safety (West 2012). Alongside this, nursing and midwifery staff must have the skills to work in multiple teams – what Edmondson calls ‘teaming’. This is not complex; it is simply the transfer of basic teamworking skills to the multiple teams that staff may be required to work in over the course of a week. These skills include ensuring clear team and individual goals, clear roles, good communication, and regular check-ins and reviews (Edmondson 2012).

The Academy of Medical Royal Colleges, based on consultation with other professionals in the NHS, including nurses and midwives, has articulated some of the key principles of MDT working and identified multiple case studies of success across the UK (Academy of Medical Royal Colleges 2020). These include the following.

- The importance of **celebrating diversity and difference** and **resisting protectionism and silo working**, which together require creating a supportive culture, promoting respect for the contribution of others, and resolving conflict effectively.
- How **inter-professional education and training** can enhance professional identity formation and teamworking skills at the outset of medical and health and care careers.
- The ongoing role of **continuing professional development (CPD), supervision, mentoring and appraisal** in stimulating a culture of shared learning and a supportive and self-reflective environment.

Nursing and midwifery professional bodies could play a valuable role by working together to jointly develop tools and resources for effective MDT and inter-team working. A recent example of this is the joint publication by the

Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (2020) of *Guidance for the provision of midwife-led settings and home birth in the evolving coronavirus (Covid-19) pandemic*.

Nursing and midwifery staff need training and ongoing support, including through protected time for teams to reflect together, to continuously develop their MDT and team leadership skills from the beginning of their undergraduate education onwards. These are not complex or difficult skills to learn, and several programmes for developing effective teamworking in health and care have been developed in the US, the UK and other settings (West and Coia 2019). Teamworking and team leadership skills should be included as part of nurse/midwife appraisal and revalidation for developmental purposes.

There are clear links between the quality of teamworking, quality of patient care, patient satisfaction and staff wellbeing in primary care (Borrill *et al* 2000; Poulton and West 1993). Nursing and midwifery staff must work with other health and social care professionals to develop and sustain inter-professional relationships to address difficulties in working across primary, community, secondary and social care. We came across many examples in our interviews of how this has been successfully modelled during the Covid-19 crisis. It must now be made a permanent part of every nurse's and midwife's professional practice and responsibility.

With the advent of primary care networks (PCNs) in England, it should be a priority to develop supportive teams that enable peer coaching, social support, mentoring, quality improvement initiatives and action learning groups. With the scale that PCNs will create, it offers much potential for effective MDT working (Baird 2019). However, from stakeholder interviews, we heard concerns that nurses in primary care were not valued as highly as other clinical colleagues and experienced discrimination in accessing CPD. Some stakeholders highlighted the importance of cultivating and supporting nurse leadership in PCNs, and the opportunity that PCNs presented for general practice nurses to support and learn from each other across multiple practices.

Building effective teamworking in primary care and general practice is vital for staff wellbeing. Good opportunities present themselves as a result of recent developments in Scotland and Northern Ireland. The new Scottish General Medical Services Contract came into force in 2018 and aims to expand the primary care MDT, supported by the Scottish government's strategy for primary care. A key part of this is the introduction of GP clusters –

professional groupings of GP practices, represented by GPs and practice quality leads feeding into cluster quality leads. The latter have responsibility to provide a quality improvement and leadership role, and they will liaise between practices and the NHS board on quality improvement issues (Scottish Government 2019a).

GP clusters have also been introduced in Wales, supported by health boards, and are designed to enable GPs, nurses and others within a locality to collaborate (Gpone.wales.nhs.uk 2019). Northern Ireland has established an MDT initiative of GP federations with two main aims: to support and protect GP practices and to help deliver the transformation agenda in health and social care (Health and Social Care Board 2019). GP federations aim to provide better care, delivered in a more responsive way and closer to home, for patients registered on the lists of practices within the federation. The focus is on working across the local health and social care community, in collaboration with a wide number of agencies, to design and implement innovative health and care strategies and ways of delivering high-quality care.

Health and social care working arrangements must develop, prioritise and sustain effective teamworking, make provision for it (for example, by ensuring high-quality support for team leaders) and provide areas where regular team meetings can take place. Teams that regularly take time out to review and improve their performance are far more effective and innovative – such timeouts increase productivity by an average of between 35 per cent and 40 per cent and substantially improve the health and wellbeing of staff (Tannenbaum and Cerasoli 2013). All must rise to the challenge of practising effective teamworking in nursing and midwifery, given the evidence of the enormous benefits for nurse productivity and wellbeing and for their patients.

Interdisciplinary teamworking: NHS Lanarkshire Hospital @ Home service

The NHS Lanarkshire Hospital @ Home service provides care in the community for patients aged over 65 who would otherwise be admitted to hospital. Patients are referred to the team by GPs, community services, or accident and emergency (A&E) or other emergency receiving departments.

The clinical team consists of medical doctors specialising in care of the elderly, advanced nurse practitioners, community psychiatric nurses, physiotherapists, occupational therapists, and healthcare assistants who

are also trained in providing specific therapeutic interventions. The team also includes a service manager, a senior nurse and administrative support staff.

During the first clinical review, a patient can be seen by any practitioner from any discipline, followed by a clinical review from the consultant geriatrician. The patient undergoes a full care needs assessment, including medical, nursing and therapy needs. The proposed care plan is discussed with all team members and agreed, with each staff discipline carrying out treatments and reviews as appropriate. All nursing and allied health professionals are trained to deliver a range of nursing and therapeutic interventions.

The team liaises with colleagues across many different departments and service providers, including day hospitals, community services, district nurses, palliative care teams, homecare providers, social work, and acute services as well as with the patient's family and carers. The administrative support team are vital in co-ordinating referrals and organising transfers of care. Virtual ward rounds are conducted every day for care plan review until the patient is well enough to be discharged from the service.

For more information, see: www.aomrc.org.uk/reports-guidance/developing-professional-identity-in-multi-professional-teams

Royal College of Paediatrics and Child Health QI Collaboratives

The Royal College of Paediatrics and Child Health (RCPCH)'s Quality Improvement (QI) Collaborative programmes support multidisciplinary teams (MDTs) to undertake structured training in QI to develop new models of care and improve health outcomes together. Facilitated by an external trainer, the nine-month programmes comprise weekend residentials, one-day events, teleconferences, an online platform, and a final celebration.

The QI Collaborative requires applicants to sign up as teams (rather than as individuals), ensuring collective buy-in. The 'multidisciplinary' term is

interpreted in its broadest sense, to include doctors, allied health professionals, nurses, managers, and administrators.

The strength of the scheme lies in the fact that teams are brought together around a shared challenge or purpose. Since QI methodologies are new to most participants, there is no 'expert' within the team, and so traditional hierarchies are erased. All members are empowered to share ideas, and participants learn more about the skills and attributes their colleagues bring. Any conflicts that arise are resolved through democratic decision-making. These values are underpinned by the celebratory ethos of the final event.

Following the Collaboratives, teams have not only implemented specific QI initiatives but also new ways of working together in day-to-day practice. For instance, some have recognised that they need designated time for developmental meetings, not just clinical handovers. One solution has been introducing a 30-minute QI-specific team meeting before the usual MDT meeting on a weekly basis. To maintain a sense of unified purpose, teams have also established shared areas to exchange ideas, whether that be a WhatsApp thread or a team wall in the office.

For more information, see: www.aomrc.org.uk/reports-guidance/developing-professional-identity-in-multi-professional-teams

Developing multidisciplinary teamworking skills: Maudsley Simulation

Simulation is an increasingly used modality for delivering training to health professionals at undergraduate and postgraduate level. Maudsley Simulation, part of South London and Maudsley NHS Foundation Trust, is the UK's first simulation training centre focusing on mental health with the aim of improving services for all who are affected or impacted by mental health issues.

The inter-professional mental health simulation course brings together nursing, clinical psychology and medical students in a true-to-life learning environment, to help develop the students' clinical knowledge and skills in

the psychological and physical care of psychiatric patients within a multi-professional team setting.

Research into the effectiveness of student interprofessional mental health simulation has indicated that it helps participants to understand and appreciate the skillsets of other professional groups and fosters collaboration. After taking part in the training, students recognised the need to consult other colleagues to achieve the best possible outcome for patients and suggested that working with other disciplines encouraged them to be more open-minded.

For more information, see: www.maudsleysimulation.com/about-us

Key recommendation 4: Teamworking

Develop and support effective multidisciplinary teamworking for all nursing and midwifery staff across health and social care services.

How

- All health and social care organisations should regularly review teamworking and ensure that all nursing and midwifery staff are working in inclusive, stable, effectively functioning and, ideally, multidisciplinary teams freed from unnecessary hierarchical or inter-professional constraints.
- All teams should have an openly stated shared purpose and clear objectives, one of which is team member wellbeing. Team members should be clear about their roles and responsibilities. Quality improvement should be a core function of all teams.
- All teams should meet at least monthly to review and reflect on their performance, including inter-team/cross-boundary working, and to develop ideas for improved ways of working to ensure high-quality care and staff wellbeing.
- Teamworking and team leadership skills should be a fundamental part of all nursing and midwifery appraisal and revalidation processes. Team education and training and team leadership opportunities should be embedded within every health and care course curriculum and within continuing education programmes for practising nurses and midwives.

Culture and leadership

Evidence from the review

Organisational cultures have a large impact on the wellbeing of staff (Dixon-Woods *et al* 2014). Interviewees reported that during the pandemic, several factors combined to create more positive cultures in some organisations and settings, and we saw remarkable innovations, commitment and compassion from nurses and midwives in many settings. Compassionate, collective and inclusive leadership was at the heart of this. Nurses and midwives across the health and social care system have been enabled to lead by initiative and example, working flexibly and collaboratively at remarkable pace. They have been able to make decisions as professionals, based on patients' needs, freed from some of the hierarchical and bureaucratic constraints that have previously eroded their professional autonomy.

Organisational culture is shaped by the nature of its leadership. It is the behaviour of leaders – top to bottom and end to end, individually and collectively – that powerfully determines whether care quality is the priority. Where all staff have clear objectives and where there is enlightened people management, there are high levels of staff engagement, learning and quality improvement are embedded, and good team and inter-team working is endemic (Dixon-Woods *et al* 2014).

Research on climate and culture in health care internationally suggests that leadership cultures of command and control are less effective than more engaging and compassionate leadership styles in health care systems across the world and implies that compassionate and collective leadership approaches are likely to be most effective (West *et al* 2014; Dickinson *et al* 2013). The box below sets out the principles of compassionate, inclusive and collective leadership.

Compassionate, inclusive and collective leadership

Compassionate leadership comprises four elements (West *et al* 2017).

- **Attending:** being present with and 'listening with fascination' to those we lead. This involves noticing and inquiring about suffering or distress, and challenging approaches oriented to blame and punishment (Kline 2002).
- **Understanding:** appraising the situation that those we lead are struggling with to reach a measured understanding, ideally through open dialogue with them. This is grounded in the assumption that others are good,

capable and worthy of value. It involves withholding blame by focusing on learning.

- **Empathising:** Being able to feel the distress or frustration of those we lead, without being overwhelmed by this emotion and therefore unable to help. This involves listening without needing to solve or intervene.
- **Helping:** Taking thoughtful and intelligent action to help those we lead, focusing on what is most useful for them.

Compassionate leadership does not involve compromising our commitment to good performance management, having difficult conversations, making radical changes or being able to challenge the status quo.

Inclusive leadership is about ensuring equality, positive diversity, and that the voices of all are meaningfully heard in the process of delivering and improving care. Truly inclusive leadership involves positively valuing difference and prevents those who are most powerful having control over team and system working.

Collective leadership involves shifting from traditional command-and-control structures and 'heroic' individual leadership towards a model that shares and distributes leadership to wherever expertise, capability and motivation sit within organisations. It means everyone listening to and supporting each other and taking responsibility for the success of the organisation as a whole (West *et al* 2014).

Caring for the health and wellbeing of others is an intrinsically compassionate behaviour. Virtually all those who work in health and care services have dedicated a large part of their lives to caring for others. Compassion is important to them and the extent to which their organisations also mirror in practice that value of compassion will influence the value 'fit' between health care workers and their organisations. The stronger that fit – the alignment of individual and organisational values – the higher the levels of staff members' commitment, engagement and satisfaction (Greguras *et al* 2014).

Compassionate leadership embodies both a sensitivity to the challenges faced by colleagues in health and care and a commitment to help them respond effectively to those challenges and to thrive in the process of their work.

We heard in our interviews that in some organisations, compassionate leadership and collective leadership have become the new normal during the

pandemic, shaping more supportive and engaging cultures. Leaders have been listening and asking 'What can I do to unblock things?' We heard that, for some staff, leaders have been doing things with them, rather than to them, by being more supportive, appreciative and sensitive, by communicating helpfully, and by being proactive in helping them rather than brushing difficulties aside. In some organisations, this style has replaced the command-and-control style that had strangled initiative and goodwill. Leaders have also been collaborating across team and organisational boundaries, prioritising care overall rather than just their areas of responsibility.

But before the pandemic, it was clear that many cultures were not being shaped to support high-quality care for patients and staff. Data from the national staff surveys, discussed below, reveals unhappiness among nurses and midwives across the UK about the culture and leadership of their employing organisations. The survey results showed that the cultures of NHS organisations are not effectively meeting nurses' and midwives' needs for autonomy, belonging and contribution.

Organisational values

Only 62 per cent of nurses and midwives in Wales and Northern Ireland would recommend their organisation as a place to work. While 77 per cent of nurses and midwives in Northern Ireland, 72 per cent in Wales and 77.6 per cent in England felt that patient care was their organisation's top priority, around 1 in 4 did not share that view. Only 40 per cent of nurses and midwives in Wales believe that their organisation is committed to helping staff balance their work and home life (NHS England 2020b; Gov.wales 2018; Department of Health 2016).

Support from senior management

In the NHS Wales Staff Survey 2018, though 74 per cent of nurses and midwives were satisfied with the support they received from their immediate manager, this still means that more than 1 in 4 were not satisfied. Fewer than two-thirds (62 per cent) of nurses and midwives in Northern Ireland were satisfied with the support they received from their immediate manager.

In Wales, only 42 per cent say senior managers lead by example, 40 per cent say that communication between staff and senior managers is effective, and 32 per cent say senior managers appreciate what it is like to work on the front line; only 29 per cent say communication between staff and senior managers is effective. In England, 45 per cent of registered nurses and

midwives say communication between staff and senior managers is effective (NHS England 2020b; Gov.wales 2018; Department of Health 2016).

Other support

Most nurses and midwives in Wales complain of a lack of timely information to enable them to do their jobs well and of poor interdepartmental co-operation. Only a minority (41 per cent) can meet all the conflicting demands on their time at work and only 26 per cent say there are enough staff for them to do their jobs properly (Gov.wales 2018).

The percentage of registered nurses and midwives in England in the 2019 NHS Staff Survey reporting involvement in changes affecting their work (57.5 per cent), and adequate materials, supplies and equipment (55 per cent) are low. And, as in Wales, more than one-third say their teams do not meet frequently to discuss the team's effectiveness (NHS England 2020b).

There was widespread concern expressed during our consultation that the response to safety failures was often to blame nurses and midwives rather than develop systems to avoid recurrence. We have already described initiatives such as Mersey Care's restorative culture programme as a constructive response to these concerns (see 'Creating just cultures: Mersey Care NHS Foundation Trust' on page 50).

The Scottish government has rightly introduced the organisational Duty of Candour, which came into force in April 2018, to implement consistent responses across health and social care providers to an unexpected event or incident that has resulted in death or harm (Scottish Government 2019b). Each NHS board must now publish an annual report on its website on how it has implemented the Duty of Candour. A complementary set of principles introduced in Scotland in 2015 is the Being Open Principles, which set clear expectations regarding openness with patients, families and, importantly, staff (Healthcare Improvement Scotland 2015). It is vital that these initiatives, and those like them, are implemented in a way that also supports staff so that they perceive a culture of psychological safety focused on learning rather than blame.

Some interviewees highlighted the pressures associated with senior nursing and midwifery roles, and particularly nursing director roles on NHS boards, which often involve huge portfolios – including responsibility for quality – and can be exacerbated by the fear or occurrence of high-profile investigations

that feed into cultures of blame. We heard from interviewees and focus group participants that these factors can discourage people from wanting to progress into more senior roles. Several interviewees recommended introducing better opportunities for coaching and peer support for these roles to help address some of these concerns.

Following the Sturrock review on bullying and harassment at NHS Highland, the Secretary for Health and Sport set up a Ministerial Short Life Working Group for the learning to apply across Scotland to build supportive cultures that engender and encourage the right behaviours (Gov.scot 2019). The report made specific proposals on leadership, peer support, and training management and HR work, to achieve a new behavioural and attitudinal approach.

These issues also relate to nurses' and midwives' working relationships with each other. In our engagement across the UK we heard examples of a minority of nurses and midwives treating nursing students or colleagues aggressively or rudely. This deeply undermines psychological safety and thereby learning and improvement.

These are all issues of organisational culture, revealing some of those aspects of culture that can undermine nurses' and midwives' wellbeing and effectiveness. Developing cultures of high-quality care for patients and for nursing and midwifery staff requires the courage of compassion from all leaders.

Good practice

How can the leadership of health and care organisations nurture cultures of high-quality, continually improving and compassionate care and, at the same time, ensure the wellbeing and intrinsic motivation of all those they lead? Research across health and care suggests that these are interdependent outcomes (Dixon-Woods *et al* 2014). Compassionate, inclusive and collective leadership is central to delivering high-quality care, staff support and positive cultural change.

There is a collective aspiration across the four UK health and care systems to develop compassionate and inclusive collective leadership. This is done through the development of the People Plan by NHS England; in Northern Ireland, through the Health and Social Care (HSC) Collective Leadership Strategy; in Scotland, through Project Lift (a leadership programme across health and social care offering multi-professional development opportunities

to established and potential leaders); and in Wales, through the new Workforce Strategy for Health and Social Care. The challenge is to ensure that these commitments are translated into practice. Regulators and quality improvement bodies should review how they can work together and align their approaches in order to nurture and sustain a shared model of compassionate, inclusive and collective leadership.

Listening to staff during Covid-19: Northumbria Healthcare NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust (NHCT), a provider of hospital, community and social care in north-east England, uses real-time staff experience data to drive improvement and innovation. This work is led by Annie Laverty, the trust's Chief Experience Officer, the first post of its kind in the NHS, with board-level responsibility for patient and staff experience. In the 2019 NHS Staff Survey, staff rated the organisation as the best acute and community trust and best acute hospital trust in England, and the trust scored highest nationally for health and wellbeing, morale, and equality, diversity and inclusion.

As the pandemic started, the trust adapted its staff engagement platform to develop Corona Voice – a short web-based survey that enabled staff to raise issues, voice concerns and share their experiences in real time. Each week, staff were asked to rate their motivation for work on a scale of 1–10, alongside a varying set of 3–4 additional questions.

In the first three months, the survey received 10,400 responses. Each week, more than a third of responders left additional information through free text comments. These comments were formally analysed, with key themes disseminated across the executive team and Silver and Gold Command. Measurement and evaluation were supported by dedicated data analysts within the patient and staff experience team, as well as researchers at Open Lab at Newcastle University.

The trust used this data to inform an evolving action plan focused on meeting the changing physical, social and emotional wellbeing needs of staff during the peak of the pandemic and beyond. Interventions carried out have included: weekly wellbeing calls for those shielding at home or not at work; daily staff briefing messages tailored around themes emerging from survey feedback; and the creation of chill-out zones and a going home checklist for staff. The data enabled the trust to understand variation across

the patch, which meant it could tailor support across different locations and target the needs that staff said mattered most.

According to the trust, staff reported appreciating the sense of being listened to, the agility of the trust when responding to safety concerns, and the open and reliable communication from the organisation throughout the crisis.

Advice for others

Timely access to real-time measurement is crucial to enable a responsive and needs-led approach, alongside a willingness to be agile and flex according to the changing needs of the workforce. Pay attention to stories and data – we needed both to improve. Create your virtuous circle: regular feedback to staff about actions taken in response to their feedback helps to increase and maintain engagement.

(Judith Stonebridge, Consultant, Public Health)

For more information, see: www.northumbria.nhs.uk/blog/support-staff-through-covid19

Compassionate leadership for a healthier Wales

Based on feedback from a large workforce strategy consultation in 2019, Health Education and Improvement Wales has committed to ensuring that by 2030 leaders in the health and social care system will display collective and compassionate leadership.

The premise is that leadership makes a significant contribution to shaping the culture of organisations, and the organisation had already identified a need to change the culture in health and social care. This was reinforced heavily by the engagement and consultation that was undertaken. It was clear that leadership has a critical impact on staff experience and, in turn, this has a direct impact on the experience of the people at the centre of the service, so leadership also affects quality. There was also a commitment to the principle that compassionate leadership drives compassionate care.

Three overarching aims were agreed:

- develop a strategy to frame a consistent approach to compassionate leadership in health and social care in Wales
- establish an accessible range of leadership development resources and programmes for individuals and organisations
- develop a talent management pipeline for leadership roles.

The approach is based on research showing that compassionate leadership creates healthier cultures. Supervisors who model compassion are 2.6 times more likely to be seen as role models; compassion improves wellbeing and motivation among health and care staff – being compassionate is associated with lower depression, anxiety and distress; compassion leads to better health outcomes – care and compassion is more effective than aspirin in preventing heart attacks; and compassion leads to improved service user experience – the top three ‘wants’ from people who use services in Wales are carers who listen, who are compassionate and who explain clearly.

For more information, see: <https://heiw.nhs.wales/programmes/leadership>

Key recommendation 5: Culture and leadership

Ensure health and care environments have compassionate leadership and nurturing cultures that enable both care and staff support to be high quality, continually improving and compassionate.

How

- All health and care organisations should implement programmes of compassionate leadership support and development.
- This should include mechanisms to ensure that nurse leaders and other leaders of nursing and midwifery staff at all levels in the health and care system are recruited, selected, developed, assessed and supported to model compassionate and inclusive leadership.
- Assessments should be conducted to determine whether staff from minority ethnic groups experience leaders as less compassionate and inclusive than other staff, and developmental supports put in place to close the gaps for such leaders.
- Compassionate leadership training and assessment should be part of all educational interventions at undergraduate, post-registration and later

career development programmes and should be included in Nursing and Midwifery Council education standards. Leadership development programmes should be diverse and inclusive to ensure that future leaders are reflective of the wider staff and populations they serve.

- All health and care organisations should regularly review their cultures and ensure that they are continuously developing cultures of high-quality, continually improving and compassionate care for patients, and high-quality, continually improving and compassionate support for staff.

4 Contribution

Contribution

The need to experience effectiveness in work and deliver valued outcomes

The need for contribution reflects a need to experience effectiveness in what we do and to make a positive difference through our work, as well as to achieve outcomes that we value, such as to deliver high-quality care that improves patients' lives.

Nurses' and midwives' need for contribution can best be met by ensuring that **workloads** are not chronically excessive. This is the subject of the first part of this section. Chronic, excessive workload is a chief factor in staff stress-related illness, absenteeism and intention to quit. It is also a key factor predicting errors at work that can harm patients or staff, and it has a significant negative impact on patient satisfaction. Achieving workloads that support wellbeing and enable staff to flourish is dependent on having appropriate numbers and skill mixes of staff to deliver care, and on their not being excessively burdened with unnecessary tasks.

The focus of the second part of this section is **management and supervision**. Nursing and midwifery staff must have enabling and supportive clinical leadership and supervisory support, focused on removing obstacles to their work and ensuring that they have the resources, support, time and reflective space to practise effectively, safely and sustainably, and to continually develop throughout their careers. There must be an emphasis on learning and accountability rather than blame and directive control.

The final part of this section focuses on **learning, education and development**. Nursing and midwifery staff must have access to flexible, high-quality development opportunities throughout their careers, and be supported to continually learn together, grow and develop. These opportunities must promote equitable outcomes for all nursing and midwifery staff.

Workload

Evidence from the review

I struggle every day because I cannot give the quality of care I would like to give, so I work harder and harder and at the end of the day I feel exhausted. I love being a nurse and it is all I want to do for the rest of my life, but I am looking at relocating to another country where I can have a better life–work balance and where I can look forward to going to work.

(Nurse, Royal College of Nursing 2019)

I had to come home after working my eighth consecutive weekend (12-hour rotational shift pattern) and tell my husband that I could not work until I was 60 doing 10 hours at least on my feet; no breaks or snatched or interrupted breaks and still being made to feel that staff were to blame for it. I felt exhausted and burned out.

(Midwife, Nursing and Midwifery Council 2020a)

Excessive workload is the number one factor leading to low levels of patient satisfaction, low levels of staff engagement, and failure to innovate. It is also the key factor determining nurses' and midwives' stress levels and intention to quit (NHS England 2020b). Previous research has identified workload as the most consistent influence on strain among health and care workers (Wall *et al* 1997). Unmanageable workloads are damaging nurses' and midwives' health and thereby exposing patients to potential harm.

Over recent years, nurses and midwives have been subjected to increasing demands along with inadequate staffing numbers. Surveys carried out by the RCN have shown that 55 per cent of respondents across the UK had experienced a shortfall of one or more registered nurses on their most recent shift (Royal College of Nursing 2019) and that 79 per cent (an increase from 56 per cent 10 years earlier) believed that staffing levels were insufficient to meet patients' needs (Marangozov *et al* 2017). Under such conditions, it is not surprising that 63 per cent of nurses reported feeling under too much pressure at work and that between 65 per cent and 71 per cent reported having to work extra hours on a regular basis (Marangozov *et al* 2017). Moreover, 9 out of 10 nurses who responded to one survey reported having to work through their breaks (a minimum of two 30-minute breaks away from the ward/practice on a 12-hour shift) at least some of the time (Marangozov *et al* 2017). Low staffing levels and increasing workloads are key factors

contributing to high attrition rates among nurses and midwives (Nursing and Midwifery Council 2017; Sidebotham and Ahern 2011).

Staffing levels

Never enough staff and over-worked and over-stressed is the main reason I became totally burned out. I love my job, but I must admit I would never allow anyone I care for to go into being worked to the bone like that.

(Nurse, Nursing and Midwifery Council 2020a)

Evidence and data on the high levels of nursing and midwifery vacancy rates is set out in the 'Context' section of our Introduction. Staffing levels were highlighted as a key issue in a great many of our interviews and focus groups, across all sectors and care settings. Between 2010 and 2019, the number of NHS nurses in hospital and community services in England increased by 5 per cent (although there was a 38 per cent reduction for learning disability nurses). However, this increase was well below increases in the amount of activity in hospital and community health services (23 per cent) (National Audit Office 2020).

In community nursing, findings from national surveys of district nursing staff indicate that most are experiencing problems with capacity in their teams. In a 2014 survey of district nursing staff carried out across the UK by the RCN, 83 per cent of nurses reported that there were not enough nurses to get the work done, and 75 per cent that there were not enough district nurses on their teams (Ball *et al* 2014). A survey by The Queen's Nursing Institute (2014) the same year found that 60 per cent of district nursing respondents across the UK did not believe they had enough appropriately skilled or qualified staff to deliver the patient care they thought was needed.

Analysis of data from the Organisation for Economic Co-operation and Development (OECD) conducted by the Health Foundation in 2019 suggested that since 2001, the UK has produced a significantly lower relative rate of new nurse graduates than most OECD comparator countries, and that it has not shown the same increase in recent years as some, including Germany, the US and Australia (Buchan *et al* 2019b). From 2017, the government changed the funding arrangements for nursing degree students in England, a major source of new NHS nurses, with Health Education England no longer responsible for commissioning undergraduate nursing places. The changes also removed NHS bursaries for nursing students, moving them on to the existing student loan

arrangements (though in December 2019, the government introduced new maintenance grants for nursing students in England from September 2020). In the two years following these changes, the number of applicants fell by almost a quarter, with a lower figure in 2019 than in 2017. In Scotland, where the NHS bursary was retained and the national government continues to commission undergraduate nursing places, applications in 2019 were at their highest-ever level, and commissioned student and midwife numbers have increased year on year for the past five years (Buchan *et al* 2019b).

Work pace and complexity

Related to staffing levels are also the pace of work, multiple concurrent demands, long hours, administrative burdens, role ambiguity, and the emotional toll of working with illness and trauma (West and Coia 2019). Work intensity has increased because patients are sicker, more often have co-morbidities or other complicating factors, and throughput of patients is faster.

Our interviews highlighted that work pace is a widespread issue, especially where nurses and midwives have little control over the number of patients attending (for example, in emergency medicine or maternity) or where there are time pressures, such as having to complete multiple tasks within a specified period. The combination of high demands and low control is particularly toxic.

Midwives have seen increasing complexity, with older women and an increased prevalence of underlying health conditions, often needing to be managed with reduced ratios of staff to women. The emotional, cognitive and physical demands of their role have increased while control over complexity and throughput have decreased (Royal College of Midwives 2017).

Interviewees reported that during the pandemic, many nurses and midwives have had to cope with additional short staffing due to staff self-isolating, being in a vulnerable category or because of Covid-19 infections. Moreover, for many, the radical changes in duties have created yet further demands. Nurses and midwives have voluntarily moved into different roles and teams to support their colleagues, needing to form new teams very quickly; the reported successes that we heard about are a tribute to their professionalism.

High job demands along with inadequate staff numbers and other resources increase the risk of burnout, anxiety and depression, work-related stress, and low work engagement among nurses and midwives (Kinman *et al* 2020;

Carter and Tourangeau 2012; Johnson *et al* 2012; Mark and Smith 2012; Currid 2009).

Unnecessary work

Pressure to achieve targets, demands to follow procedures which duplicate practices, and increased paper exercises which impact on practice and decision-making.

(Community nurse, Royal College of Nursing 2013)

As a senior specialist nurse, I found myself spending too much time auditing and reporting to commissioners and not actually caring for my patients. The culture in the NHS has become far too much about numbers and not about the people who really matter, the patients.

(Nurse, Nursing and Midwifery Council 2020a)

Bureaucracy and administrative tasks (many of which are seen by staff as unnecessary) add significantly to nurses' and midwives' workload, creating stress and dissatisfaction (Common 2015; Royal College of Nursing 2013; McCloskey and Taggart 2010). Being required, despite this, to take on these additional responsibilities takes time away from patient care and from reflective development, increasing the risk of moral distress. We recognise that some administrative tasks, though they do not contribute directly to individual care, are critical for safety and for ensuring that work gets paid for. Nevertheless, East London Foundation Trust (for example) has eliminated 85 per cent of clinical audit activities with no deleterious effects on patient safety or care quality (see 'Jointly reducing workload: East London NHS Foundation Trust', below). Nurses across the UK report spending too much time on non-patient-facing duties, particularly in independent sector care homes (60.8 per cent), NHS trusts/boards (58.1 per cent), student nurses (51.5 per cent) and in independent sector hospitals (53.1 per cent). This is much less true in general practice settings, though even here, more than 1 in 4 nurses indicate they spend too much time on non-nursing duties (29.2 per cent) (Royal College of Nursing 2019).

In the most recent NHS Wales Staff Survey, only 41 per cent of nurses and midwives said they could meet all the conflicting demands on their time at work and only 26 per cent said that there were enough staff to enable them to do their job properly (Gov.wales 2018). The respective figures in the 2019 NHS Staff Survey in England for registered nurses and midwives were 42.3 per cent and 28.6 per cent; and in the HSC Northern Ireland 2015 Staff

Survey, 39 per cent and 28 per cent (NHS England 2020b; Department of Health 2016). Comparable data is not collected in Scotland. In the RCN survey, 61 per cent of staff who responded indicated that they were too busy to provide the level of care they would like, and 63 per cent reported feeling under too much pressure at work (Royal College of Nursing 2019).

As we look to the future, nurses and midwives cannot be expected to manage the existing level of work demands, let alone take on more. The workload is unsustainable, damaging nurses' and midwives' physical and mental health, undermining quality of care, and (despite their dedication) reducing staff commitment and engagement (Kinman *et al* 2020; West and Coia 2019).

Good practice

A vital element of leadership is addressing courageously and persistently the key factors that have an impact on the core mission of nursing and midwifery and devoting attention to the most significant challenges in the workplace, particularly workload. This will require a fundamental shift in nursing and midwifery practice; transformational and innovative approaches are needed, including a commitment to embed continuous improvement approaches.

Among key themes that emerge when considering nursing and midwifery excessive workloads are having the right number and skill mix of staff, improving IT, reducing bureaucracy, ensuring more time with patients, developing a culture that protects time for learning, having breaks, improving MDT working, having time for reflective practice, and amplifying nurses' and midwives' voices in their local health and social care system (West and Coia 2019).

Across the UK there has been a recognition by the four governments that having more nursing and midwifery staff is fundamental to meet growing demands for health and social care, even before the onset of the pandemic (Scottish Government 2019c; Department of Health Northern Ireland 2018). Equally important is ensuring that staff are retained and that they stay well by creating working conditions that enable them to flourish.

Since 2017, in England, NHS England and NHS Improvement has supported several trusts with an intensive retention support programme. Over the previous decade, increases in numbers recruited were matched by numbers leaving. The retention support programme, which started in 2017, has reduced leaver rates in those trusts receiving support from the programme and is focused on addressing key reasons for leaving, including career

progression, health and wellbeing, and support for new starters (NHS Improvement 2019).

Role development in multidisciplinary teams

Training and recruiting more nursing and midwifery staff can be supported by changes to the way nursing is practised to increase the support for and thereby the productivity of nursing and midwifery staff. There must also be a bolder move towards deploying alternative professionals in multidisciplinary teams to build a mixed skillset for use on the front line of nursing and midwifery, in primary, secondary, and community care as well as the independent care sector. Many tasks can be transferred between professionals working both in specialist units or in multidisciplinary teams (World Health Organization 2008).² There are potential benefits for all from more flexible ways of working, enabling skill development, task variety and reduced workload (De Dreu *et al* 2001).

A nursing degree apprenticeship route into nursing and a new nursing associate role, intermediate between registered nurses and healthcare assistants, have been introduced (NHS Employers 2020). The nursing associate is a new support role in England that bridges the gap between health care support workers and registered nurses. Nursing associates provide hands-on, person-centred care as part of the nursing team in a variety of settings in health and social care. Skills for Care is working with Health Education England to increase the number of nursing associates being trained and employed in social care (Skills for Care 2020).

There are many examples both before and during the pandemic of health and care professionals working more flexibly. In our interviews, we heard that maternity support workers in England are easing some of the demands on midwives as they have become an integral part of the maternity team. The addition of maternity care assistants in Scotland has also proved a big success, according to interviewees. The Royal College of Midwives argues that some of the work currently undertaken by midwives could more efficiently be done by other staff. This would include round-the-clock provision of clerical staff in busy maternity units, increased use of maternity support workers

² We avoid the term 'task-shifting' as it implies a mechanistic, non-collaborative and short-term approach to what should be a set of processes focused on role development, task variety, task identity, skill development and task meaningfulness in the interests of patient care and nurses' and midwives' wellbeing.

where appropriate (such as to support a midwife attending a home birth), and not using midwives in operating theatres, alongside the use of IT systems that minimise the need for multiple entry of data (Royal College of Midwives 2017).

Other changes that have been shown to have had a positive impact were those that enhanced communication between health and care professionals. Relocation of staff so that teams are co-located, frequent team meetings, leader updates, regular team meetings to discuss concerns, and daily multi-professional team huddles to review the patient list appear to significantly improve productivity, staff satisfaction and wellbeing (West and Markiewicz 2016; Sinsky *et al* 2013).

New technology

We heard from interviewees that during the pandemic there have been many innovative uses of technology to free up nurses' and midwives' time, which helped to support more sustainable working. These include using automated chat services and phone and video consultations.

Interviewees told us that district nursing stands to benefit significantly from well-designed digital support, especially where it enables remote working. For example, tablet computers with access to caseload lists and patients' notes have the potential to improve efficiency and productivity, as well as to enhance quality and safety through timely access to notes at the point of care, and supporting communication between professionals.

Relationships with patients and community

Channelling community energy to foster a new relationship with public services – creating citizen-led public services – has long been an aspiration in England. Interviewees described how, during the pandemic, there have been examples of how enhanced working relationships between citizens and local health and care services can also help to ease workloads. We heard examples of more mutual, more respectful, more understanding relationships with patients based on shared decisions. And we heard examples of how the community has stepped up to help by volunteering, donating and innovating to support and ease demands on health and care home staff.

There is now an opportunity to truly reshape the relationship between public services and the communities they serve, fostering cultures where public services seek to build on the strengths and assets of communities to improve

outcomes. It is a different way of working that recognises the role people can play in improving their own health and supporting them to do so.

Examples of such engagement include:

- Year of Care Partnerships (www.yearofcare.co.uk)
- Bromley by Bow Centre (www.bbbs.org.uk/)
- NESTA's Realising the Value programme (www.nesta.org.uk/feature/realising-value-programme-reports-tools-and-resources)
- The Frome Model (www.compassionate-communitiesuk.co.uk/projects).

Freeing up senior charge nurse time through administrative support: NHS Ayrshire and Arran

In 2015, two senior charge nurses (SCNs) at University Hospital Crosshouse hired an administrative assistant to create time for supervision, quality improvement and patient care. They carried out a review, which showed that 70 per cent of their administrative tasks could be done by an administrative assistant, who could do those tasks in 30 hours rather than the 40 currently being spent by the SCNs.

The administrative assistant was shared between the two SCNs, carrying out functions like inputting audit data, managing diaries, staff attendance and training schedules. With their additional time, the SCNs were able to deliver more scenario-based teaching, lead ward rounds, and spend more time with patients and their teams.

Patient safety and staff experience have both improved significantly through the creation of this role. The total number of falls between January and May declined from 38 in 2015 to 6 in 2017, with no falls resulting in harm to patients and no avoidable pressure ulcers, despite their patients being in high-risk categories for both. The proportion of staff undergoing mandatory and statutory training rose from less than 50 per cent in 2013 to 87 per cent in 2017.

The administrative assistant post, initially a pilot, was made permanent, funded by the nursing budget, sitting within the nursing management structure and line-managed by the two SCNs. In response to early concerns that there would not be funding available for the role, the SCNs pointed out

that 'paying a band 7 nurse to spend 20 hours of her working week to complete admin tasks that an administrative assistant could do more effectively did not seem a good use of limited funds'.

For more information, see: www.nursingtimes.net/roles/nurse-managers/freeing-up-senior-charge-nurses-time-through-admin-support-19-02-2018

Midwife-led outpatient induction of labour: Belfast Health and Social Care Trust

A multidisciplinary project group at the Belfast Health and Social Care Trust, consisting of consultant obstetricians, a consultant midwife, midwives and a service manager, used a quality improvement methodology to set up a team of midwives responsible for outpatient induction of labour.

The team consists of one band 7 and two band 6 midwives and two maternity support workers, trained and supported by a consultant obstetrician. They use cervical balloon catheters (CBCs), rather than pharmaceutical induction of labour agents. The midwives are trained in CBC insertion, enabling them to carry out tasks previously performed by medics. The consultant obstetrician supervises, assesses and signs them off as proficient.

Team members have ownership over their working patterns and scheduling of the induction of labour activity. Previously, activity scheduling was carried out by a variety of staff and did not take into account complexity of need and skill mix. The team now plan schedules together in collaboration with the intrapartum team to ensure an even workload that reflects the need and complexity of the women they care for. The team also has more scope to tailor the induction of labour process for women, drawing on support from obstetrics colleagues when needed. The team communicates regularly with delivery suite sisters to co-ordinate care and progress women's care pathways. Both teams report greater confidence in the induction of labour pathway and in the way they work and plan together.

According to the trust, team members report high levels of job satisfaction, and 93 per cent of service users rated the service as excellent or very good.

The trust is now working to embed this service model, and newly qualified midwives will rotate through the service as part of their preceptorship.

Advice to others

Keep close contact between the multidisciplinary working group and the team. Start small and build things up from there. Engage senior leaders early and give them robust assurance that midwives will be well-trained and assessed. Celebrate your successes!

(Margaret Rogan, consultant midwife, Belfast Health and Social Care Trust)

Jointly reducing workload: East London NHS Foundation Trust

East London NHS Foundation Trust (ELFT) provides mental health and community services to approximately 1.5 million people. In 2013, the trust reviewed all clinical audits with a group of stakeholders, including service users and staff, to identify which activities really added value. This allowed it to stop 85 per cent of all audit activity and led to a broader campaign to encourage people to identify non-value-adding activity. The reduction of audit activity was in part facilitated by the trust's extensive commitment to quality improvement.

In 2014, the trust invited every team to identify activities that provided little value to patients or staff. The participation was high, and the trust grouped the responses received into three themes: ideas related to duplication of meetings; unnecessary travel to trust HQ for training; and duplication of recording clinical information. It acted on those three areas, trialling combining meetings or even stopping them all together; having a group work on provision of training; and absorbing feedback into existing clinical transformation workstreams and systems configuration. It then further encouraged all teams to have a discussion, using an introductory podcast from the senior management team, to help identify something they spent time on that added little value and to explore the kinds of changes that could help address this.

In March 2017, a campaign at ELFT encouraged all staff to 'break the rules'. Staff were encouraged to highlight any bureaucratic and unnecessary rules that could be eliminated to focus more on what was important and valuable

to service users, carers and staff. More than 100 unique ideas were submitted. All the ideas raised were shared with staff on the intranet, who were encouraged to vote for their favourite. The leadership team considered all the suggestions and shared responses daily through the intranet on the ideas submitted and on how the system was being redesigned to make them possible.

For more information, see: www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

Key recommendation 6: Workload

Tackle chronic excessive work demands in nursing and midwifery that exceed the capacity of nurses and midwives to sustainably lead and deliver safe, high-quality care and which damage their health and wellbeing.

How

- All organisations that oversee the work of nursing and midwifery staff must continually undertake, in collaboration with nursing and midwifery staff, a programme to review workload in their organisations.
- Assessments should be conducted to determine whether staff from minority ethnic groups experience higher levels of chronic excessive workload than other staff, and developmental supports put in place to ensure equity.
- Initiatives under way across the UK to increase staffing numbers must be reinforced, given the large number of vacant posts.
- A variety of approaches to addressing workload must be undertaken in concert, including the following.
 - Programmes to deploy and develop alternative roles, such as administrative support staff and maternity support workers, to enable nursing and midwifery staff to work at the top of their competency, supported by effective multidisciplinary teamworking in all areas of health and care.
 - A continual review of tasks, activities and processes that do not add significant value either to patient care or staff wellbeing.
 - A continual review of new technologies being used in UK health and care systems to increase efficiency and reduce workload.

- A programme of continuous process improvements (using QI approaches) especially through collective discussion in regular team meetings.
- Engaging communities, community representatives, patients, their families and carers in taking shared responsibility for their health and care services.

Management and supervision

Evidence from the review

In a pressured modern workplace, lack of support from and of regular access to a supervisor has a negative impact on the work experience of nursing and midwifery staff in relation to their core work needs. Having a supportive, approachable manager helps nurses and midwives feel confident that support is available for personal and professional issues and development (Royal College of Nursing 2013; Yoshida and Sandall 2013).

Nurses' and midwives' need for autonomy does not imply that they practice independently or without accountability. Health and care require good teamworking and clear accountability. However, some nurses and midwives told us that managers can be challenging, aggressive and intimidating, which undermines their sense of effectiveness and affects their mental health. Compassionate and encouraging leadership and management by nursing and midwifery leaders, line managers and senior management benefit the mental health of nurses and midwives. Equally, compassionate supervision conversations lead to better allocation of workload, access to resources, and the removal of obstacles that impede high-quality care from nurses and midwives (Chandler *et al* 2000).

Clinical supervision is an activity that brings together skilled supervisors and practitioners (one to one or in a group) to reflect upon their practice and learn how to improve, adapt and cope successfully. Interviewees noted that clinical supervision is more common in mental health nursing and midwifery than in general nursing (although they pointed out that this varies across the four UK countries) (see, for example, Gov.wales 2017).

Supervision can: support nursing and midwifery staff in dealing with complex care situations; help them explore and deal with their personal and emotional reactions to their work; and help them to reflect on, challenge and change their own practice in a safe and confidential environment (MacLaren *et al* 2016; Care Quality Commission 2013). It provides an opportunity for

supportive reflection where staff are encouraged to share their challenges. There is considerable evidence of the importance of good supervision for care quality and for staff wellbeing (West and Coia 2019; West and West 2015). Good, supportive supervision reduces the risk of burnout and makes nurses and midwives feel valued and supported (Kinman *et al* 2020).

Good practice

A recent Health Education England Commission concluded that all organisations should provide dedicated time for nurses and midwives to access reflective learning spaces, such as clinical supervision, especially to deal with emotional or psychological impacts of clinical incidents (Health Education England 2018). Interviewees recommended that, in settings where there may only be one or two registered nurses, employers should seek opportunities to buddy with other employers (such as through primary care networks) to ensure access to clinical supervision and CPD for their staff.

Because many senior nurses across the UK reported difficulties in finding the time to fulfil supervision roles, supervision time must be allocated in job plans of senior nurses and in the job plans of line managers in all settings where nurses and midwives work in health and social care (Labrague *et al* 2018). Effective clinical supervision increases efficiency and productivity and repays the time allocated (Care Quality Commission 2013; Kilminster and Jolly 2000).

In the NHS Staff Survey in England, nurses and midwives who reported having supportive line managers experienced higher levels of work engagement, more satisfaction with their organisation, and more satisfaction with their immediate work conditions. They were less likely to be intending to leave their organisation or the NHS (NHS England 2020b). Provider organisations, nursing and midwifery leaders and other senior colleagues must provide supportive and compassionate supervision for nursing and midwifery staff as part of national and local strategies to ensure their wellbeing and high-quality care for the people they serve.

This is borne out by many research studies. A review of 129 studies of nurse leadership showed that relational or more compassionate leadership styles were more effective in developing high-quality work environments, implementing new models of care, and nurturing health and wellbeing in a strained nursing workforce (Cummings *et al* 2018). In comparison, task-focused leadership styles were associated with lower nurse job satisfaction. The review concluded that leadership focused solely on task completion leads

to lower levels of nursing job satisfaction, retention, poorer work environment and lower productivity within health and care. Another recent review found similar results, suggesting that in health and care settings, compassionate, transformational and collaborative approaches to management and leadership lead to better outcomes for health and care workers, including nurses (Lega *et al* 2017).

It is important that supervisors, at all levels of seniority, are adequately trained to enable them to fulfil their roles effectively. This requires evaluation of training to determine its effectiveness, and regular assessment of the quality of supervision based on the principles of compassionate and inclusive leadership. The development of supervision skills should also be part of CPD throughout the supervisor's tenure in the role. Interviewees recommended the establishment of feedback mechanisms to enable line managers and supervisors to receive timely and regular feedback, in order to support the development of their management and leadership practice.

Ensuring that organisations provide resources (such as training opportunities and protected time) for appropriate supervision could be further reinforced via regulatory and inspection processes, and reflections by team members. This is a clear route to enhancing productivity, engagement and commitment of nurses and midwives across our health and care services.

Supporting newly registered nurses and those from overseas: Barking, Havering and Redbridge University Hospitals NHS Trust

Support for newly registered nurses at Barking, Havering and Redbridge University Hospitals NHS Trust has been the subject of a BBC documentary series – *Saving our nurses*. A senior intern team of experienced nurses has been created to support newly recruited nurses to deal with the challenges of their new roles. The team has reduced attrition rates from 24 per cent to 8 per cent by offering a successful mentoring and coaching programme for all new nurses. There has also been a big increase in applications for nursing places in the trust. The scheme won Preceptorship of the Year at the *Nursing Times* Workforce Awards in 2019. Chief Nurse Kathryn Halford said:

Supporting our new nurses is so important. I can remember when I first started out as a nurse, it can be disorientating on the ward for the first time and being responsible for your patients, so to have a more experienced colleague who can provide help and advice can make a huge difference.

We've recently welcomed lots of new nurses to our trust and had lovely feedback about this scheme, and it shows how we're putting our staff first.

For more information, see:

www.nhsemployers.org/news/2020/06/documentary-about-nurse-retention

The leader/leader model: Langley Green Hospital

Langley Green, an acute mental health hospital in Sussex, introduced a set of measures aimed at creating a nurturing, open, collaborative and compassionate culture, modelled from the leadership down. The measures were carried out in order to address low staff morale and to move away from poor leadership styles. Managers and staff took part in Staff Wellbeing Matters tea and chats, offering staff the opportunity to talk about what they felt did and did not work well for them in the organisation, and how they could best be supported.

Leadership was distributed throughout the organisation by implementing a 'leader/leader model'. Under this model, managers do regular shifts, are very present on the wards and have open-door policies. Staff and patients are respectively referred to as 'staff leaders' and 'service leaders' and are enabled to raise issues, influence change and create solutions, including through carrying out ward improvement initiatives. This has created a sense of togetherness and transparency throughout the hospital. Nursing and management office doors are left open, risk huddles take place each month, and 'transparency boards' detail staff training levels, incident numbers and supervision levels.

The organisation has stepped up its commitment to supervision, consistently achieving levels above 90 per cent each week. This sits alongside weekly development programmes and monthly learning forums, which drive a learning, rather than a blaming, culture. Away days are held every three months, allowing teams to reflect on the way they work and set their vision for the care they want to provide.

Over the course of these changes being implemented, sickness levels decreased, with one ward having two consecutive months of 0 per cent sickness. Medication omissions fell from 36 per cent to 0 per cent, and

agency use was reduced, saving the trust £25,000 in agency fees in just two months in 2017.

For more information, see: www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/ppimh-report---a-happy-healthy-workforce.pdf?sfvrsn=25749e62_0

Improving appraisal and revalidation: Central Manchester University Hospitals NHS Foundation Trust

Central Manchester University Hospitals NHS Foundation Trust (CMFT), which in 2017 merged with the University Hospital of South Manchester NHS Foundation Trust to form Manchester University NHS Foundation Trust, was a leading health provider in Manchester, employing approximately 3,700 registered general nurses, 380 registered midwives and 165 registered health visitors. The trust undertook a programme to align revalidation towards embedding the Nursing and Midwifery Council (NMC) Code in everyday practice, by including revalidation in the existing appraisal process and line management structure. A Deputy Director of Nursing and the Head of Professional Development led a steering group to provide strategic direction and a Revalidation Champion Group of senior nurses and midwives supported registrants and confirmers in their divisions.

Revalidation workshops for nurses and midwives gave an overview of the revalidation model and provided an opportunity for people to start putting their portfolios together. An evidence pack supported registrants in collecting their evidence and included all NMC forms and templates, aligned to the Code and CMFT values. It also included completed examples of forms and templates. Nurses and midwives were proactively assured about the value and safety of reflecting openly and honestly about negative as well as positive experiences. The trust found revalidation workshops reduced anxiety about the revalidation process and focused registrants' minds on the purpose of feedback – the importance of learning from and reflecting on it.

The trust created a standard certificate of learning for all education events to capture continuing professional development (CPD) hours and details about what staff were learning. Nurses and midwives could access evidence

of practice hours from the e-roster portal and CPD from the Oracle Learning Management (OLM) system.

For more information, see: <http://revalidation.nmc.org.uk/download-resources/case-studies/organisations/cmft.1.html>

Key recommendation 7: Management and supervision

Ensure that all nursing and midwifery staff have the effective support, professional reflection, mentorship and supervision needed to thrive and flourish in their roles.

How

- All organisations employing nursing and midwifery staff should ensure that each staff member has an appropriately trained line manager supporting them to work and develop effectively, providing regular one-to-one review meetings and ensuring that their work needs are met. There should be particular support for newly registered nurses and midwives.
- Management, support, educational and clinical supervision should be included in the job plans of line managers and clinical supervisors, and their workloads balanced to ensure they have protected time to provide these functions.
- Line managers should receive professional development to ensure they have the necessary skills, confidence and compassionate and inclusive leadership behaviours to offer nursing and midwifery staff the support they need to be effective.

Learning, education and development

Evidence from the review

Undergraduate nursing and midwifery education

When it's busy, the first thing to go is the supervision and proper learning experience. We just do what needs to be done for the patients, but some people do that for their whole placements, and you need more than that to feel ready and confident to be a nurse. And students hardly ever get recognised for the contribution they make.

(Student nurse, interview)

Nursing and midwifery students face different challenges to their peers taking other degrees, often including having to work during unsocial hours as part of intense programmes, taking place over generally longer academic years. In particular, they must face the emotional demands of health and care where they are exposed to patient suffering and experience the moral distress of decision-making and dilemmas. Stress and reported mental ill health exist in all further and higher education courses, but the education sector must work more effectively alongside the NHS and placement providers as education partners to support students on health and care courses (Health Education England 2019).

High levels of attrition from undergraduate nursing courses in England have serious consequences for nursing and midwifery workforce planning. Analysis by the Health Foundation and *Nursing Standard* found that in 2018, almost a quarter (24 per cent) of people starting a nursing degree in England either did not graduate or did not do so within the expected timeframe (this is known as the 'attrition rate'). Attrition rates varied from 5 per cent to 50 per cent between providers and differed considerably between specialisms. In midwifery, the attrition rate among providers with an intake of more than 20 students was slightly more than a fifth (21 per cent), again with significant variation between providers (Buchan *et al* 2019a). Although these figures do not distinguish between those who do not finish their course at all and those who finish late, they highlight a pressing need to improve the situation for nursing and midwifery students. Key reasons for attrition identified through our interviews and in previous research include poor experiences on clinical placements, financial difficulties and academic pressures (Health Education England 2018).

Over the course of a three-year nursing degree programme, the student must accumulate 4,600 hours of learning, of which half is theory and half clinical practice. Nursing students will work clinical placements at night, over weekends and bank holidays. Clinical placements should be a positive and value-affirming experience, promoting compassion.

I think to be a good mentor, you need to have the time for students regardless of how busy the ward may be. It is understandable that patients do come first but us students are learning to become registered nurses, and we can only do that if we are confident and competent to do so.

(Student nurse, interview)

In October 2018, Health Education England launched a report and a set of resources to support education and placement providers in reducing the level of student attrition from health and care-related courses. The Reducing Pre-registration Attrition and Improving Retention (RePAIR) report recommends what should be done system-wide to improve retention, including that learners get the most from inspirational peers and role models, meaning that nursing and midwifery students must have excellent clinical placements with well-trained and supported, inspirational, values-driven, caring, compassionate and supportive educators (Health Education England 2018).

How nursing and midwifery students are supported during their clinical placements affects the quality of their education and their retention. Poor clinical placement can lead to students quitting their courses, while good clinical placements influence the learner to see the NHS or the wider health and care system as a good employer that values staff wellbeing and cares for its people. We heard in our interviews that some interactions with other professionals made nursing and midwifery students feel at the 'bottom of the ladder', undermining their confidence and wellbeing. There were anxieties about the planning of, and the time and cost of travel to, placements. The RePAIR report found that clinical placements for nursing students can vary markedly between different placement provider organisations in England and even within the same provider (Health Education England 2018).

Health Education England recommends that all educators, assessors and placement supervisors should have appropriate training in the skills needed to support and nurture students. Moreover, it recommends that education institutions and placement providers should work in partnership to provide support for the transition stresses that students may face at course commencement, entering each clinical placement, and on taking up their first graduate role. And they propose that all students and placement provider staff should have suitable accessible spaces in which to socialise, share, discuss experiences and rest away from patients and the public.

Several interviewees highlighted the impact that financial challenges can have on students' wellbeing, with limited ability to work to earn while in training, the costs of living expenses and (in England and for some students in Wales and Northern Ireland) tuition fees (The Funding Clinic undated). The King's Fund, Health Foundation and Nuffield Trust previously recommended that the government invest an extra £560 million by 2023/34 to help address this issue, including through reinstating funding to cover tuition fees for postgraduate nursing courses and offering 'cost of living grants' of around

£5,200 a year for undergraduate and postgraduate nursing students, in recognition of the time spent on clinical placements. They also recommended improving the quality of support available to students undertaking clinical placements and diversifying the range of settings in which nursing students can undertake placements (Beech *et al* 2019). The UK government subsequently announced additional support of at least £5,000 a year to help with living costs for all new and continuing degree-level nursing, midwifery and some allied health students in England from September 2020 (Gov.uk 2019).

Post-registration training and revalidation

Once you register, people think 'there's so much I don't know, what's going to happen when people find out?' It can be really daunting. And lots of people finish their supernumerary then get suddenly moved to a new area that they don't have experience in, and all that confidence that they'd been building up gets lost.
(Student nurse, interview)

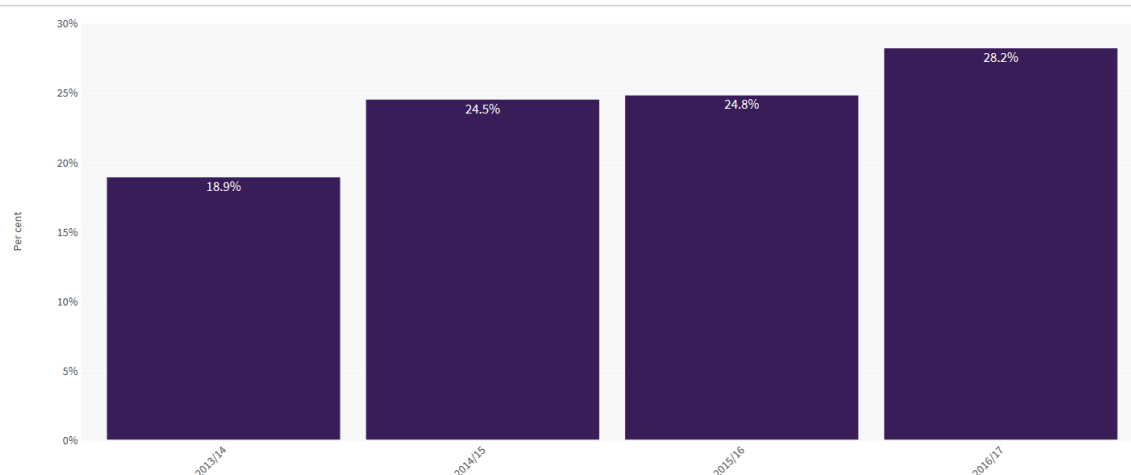
We heard from stakeholders that newly registered nurses and midwives often experience a range of pressures, worries and struggles during the early stages of their careers. A key problem identified was a lack of confidence, sometimes manifesting in 'imposter syndrome', particularly in cases where their first rotation takes place in a different setting to where they did their placements. We also heard of the frustrations and disillusionment that can result from a culture of what was sometimes referred to as 'nurses and midwives eating their young', which included resistance among some teams to newly registered nurses and midwives trying to help introduce quality improvements and new ways of working, wearing down their energy and enthusiasm for evidence-based practice.

Revalidation has the potential to raise standards of care and drive CPD. Revalidation is the process that all nurses and midwives in the UK and nursing associates in England must follow to maintain their registration with the Nursing and Midwifery Council (NMC). Initiated in April 2016, revalidation is intended to support nurses, midwives or nursing associates to demonstrate that they practise safely and effectively. It is designed to encourage them to reflect on their practice and demonstrate that they are 'living' the professional standards set out within the NMC Code (Nursing and Midwifery Council undated). Nurses and midwives must revalidate every three years to renew their registration. Interviewees stressed the importance of employers viewing

and using the revalidation system as a tool for improvement, including by ensuring that staff have sufficient dedicated time and support to reflect, to take part in learning opportunities and reflective discussions, and to engage properly with the revalidation process.

Available data supports the suggestion that early-career nurses and midwives have specific and pressing support needs (Gray *et al* 2020). Data from NHS Digital indicates that in hospital and community services in England in 2016/17, 28 per cent of staff leaving the nurse and health visitor NHS staff group left within the first three years of their service (see Figure 3). This proportion has risen by nearly 50 per cent since 2013/14, suggesting a growing urgency in the need to address the issues facing these groups. At a time when the retention of nursing and midwifery staff is such a significant national issue, attention must be paid to these early years of training and work experience with the aim of transforming nurses' and midwives' experiences.

Figure 3: Percentage of nurse and health visitor leavers who left within three years of service 2013/14 to 2016/17



Source: NHS Digital • Experimental sample data from NHS Digital used. Leavers are staff that have left the Nurses & Health Visitor staff group to other staff groups or to outside the NHS.

TheKingsFund>

Interviewees told us that what early-career nurses and midwives need is nurturing support from teams and supervisors, as well as the confidence of having a structured and properly resourced path for development. Employers need to understand what can be reasonably expected from newly registered nurses and midwives, in line with the NMC standards, as well as the pastoral and developmental needs that must be met to support them through this challenging career stage – and to capitalise on their energy, enthusiasm and ideas.

Among newly registered student nurses in London, the odds of those from minority ethnic groups securing jobs at interview were less than half of those from a 'white' ethnic background being offered a job. Confidence among minority ethnic candidates and their sense of preparedness for the job search process were also significantly lower (Harris *et al* 2013). There is much work to be done to ensure fairness in the experiences of students from minority ethnic backgrounds and in the appointment of newly registered nurses.

Throughout their careers, education and development improve nurses' and midwives' competencies, helping them to become competent, confident, skilled practitioners and clinical decision-makers. Education and development opportunities contribute to nurses and midwives feeling valued, respected and supported by their organisations. And such growth and development experiences therefore help to meet nurses' and midwives' needs for contribution, effectiveness and control (Kinman *et al* 2020; West and Coia 2019; Alfes *et al* 2013; Cousins and Donnell 2012).

Later career development

Interviewees told us that many nurses and midwives are planning to retire early, which will increase burden on those that remain in the profession. The feedback we heard suggests that one of the underlying causes may be the limited opportunities they have to learn or develop professionally.

Interviewees also suggested that work is needed to enable experienced nurses and midwives to continue to contribute without doing only patient-facing work and in a way that reduces the impact of shift work – for example, through flexible working arrangements and involving them in teaching, training, mentoring and support for nurses and midwives and for developing MDT working, thereby reaping the benefits of their experience.

Good practice

Simple things make a huge difference, like making sure people have their lanyards and access cards so they can feel part of the team and the organisation straight away. Don't just call people 'the student', take the time to learn their names like you would with any other new team member.

(Student nurse, interview)

Knowing your shifts a few weeks in advance is so helpful because it means you can book in childcare or bank shifts to earn the money you need. It shouldn't feel like such a huge win for a student to get their

shifts a few weeks in advance, it should just be normal.

(Student nurse, interview)

Mentors have played such an important role to me as a student nurse, not only for my learning experience but on my sense of belonging and mental wellbeing too... My last mentor put trust in me and let me work truly autonomously, which really enabled me to grow my nursing wings and gain confidence in my own ability to assess a patient fully.

(Student nurse, Health Education England 2019)

Undergraduate and postgraduate curricula must be designed to ensure that students have the tools to support their own wellbeing, develop a compassionate approach to care, work effectively in multidisciplinary teams, and develop their compassionate and inclusive leadership skills.

Education providers could ensure that students have membership of a stable 'home team' that meets regularly and provides the student with a sense of belonging. A home team is a relatively stable team and is the team that individuals most identify with as providing their support and direction (West 2012). Interviewees also stressed the importance of early, comprehensive and effective inductions when starting placements, as well as of staff support for student placements being properly recognised by placement provider organisations, including by ensuring that experienced nursing and midwifery staff have protected time for providing such support.

Preceptorship programmes appear to help newly registered nurses and midwives by providing opportunities for nurses and midwives to talk about their concerns, get advice, and build their confidence during this challenging transition (Marks-Maran *et al* 2013). Crucially, they help to embed confidence, particularly in cases where nurses and midwives start work in unfamiliar care settings or with new teams. However, we heard from interviewees that there was wide variation across organisations in terms of the duration of such programmes and the level of support given. To help address this, the recently published NMC principles of preceptorship should be applied within all health and care organisations (Nursing and Midwifery Council 2020b).

We heard from interviewees that more can be done to support nursing and midwifery staff coming from overseas to work in the UK. Employers could review the experience of international staff to identify key needs for this group and help direct efforts to better support them, particularly in terms of helping new arrivals to settle into living and working in the UK. There is also a

potential role for professional bodies and the NMC to play in supporting this group. Both the General Medical Council (GMC) and the British Medical Association (BMA) provide information, advice, tools and resources for doctors trained outside of the UK, and the GMC offers free, half-day 'Welcome to UK practice' workshops in each of the four UK countries (British Medical Association 2020; General Medical Council undated). It would be worthwhile for nursing and midwifery professional bodies and the NMC to explore developing similar support offers, alongside the Immigration Advice Service already provided by the RCN (Royal College of Nursing undated).

Nursing and midwifery staff at the later stages of their careers can offer much knowledge, skill, experience and particularly richness and depth of clinical knowledge. Their life experience may also give them increased empathy and understanding for patients and families, as well as equipping them for mentoring and leadership roles (Health Education England 2018; Mion 2006). With the move towards wider role development in nursing and midwifery, there will be a significant need for teaching, training, mentoring and support for MDT working. Experienced staff are well-placed to provide this.

Supporting newly qualified midwives: Cardiff and Vale University Health Board

In response to high attrition rates among newly qualified midwives and feedback calling for improved support, Cardiff and Vale University Health Board instituted a 'prep for practice' programme to develop a more supportive and nurturing environment for them. The programme was developed by a team of midwives, a clinical supervisor of midwives and the practice facilitator, and was informed by feedback from current newly qualified midwives.

The team worked with university leads to institute 'continuity placements', where students' final placements matched their first clinical rotations when newly qualified. This was intended to give them greater familiarity and confidence in their first rotations and to allow them to build on the skills they had developed as final-year students. Students were allocated mentors who would become their 'continuity preceptors', allowing them to maintain an ongoing supportive relationship through the transition from student to newly qualified staff, and enabling them to have a familiar face in the clinical area during their first rotation.

The preceptorship programme was adapted with a focus on structure, confidence-building and integrating newly qualified midwives into their teams. Preceptees were offered protected supernumerary status for two weeks, followed by two weeks working the same shifts as their preceptors. They were provided with badges to enable colleagues from across the multidisciplinary team to identify them as potentially needing additional support. Preceptees reported that this helped them feel safer and less vulnerable during their shifts. A full-team WhatsApp group was set up as a forum for support and communication, and monthly meetings were scheduled for preceptees to share their experiences and raise issues.

A questionnaire of the first cohort of 'prep for practice' preceptees and the previous cohort of preceptees showed considerable improvements in their experiences. In answer to the question 'Were you supported during the preceptorship programme?', 100 per cent of respondents from the 'prep for practice' cohort either agreed or strongly agreed, compared with 45 per cent among the previous year's cohort. All but one of the cohort continued working at the health board after their preceptorships had ended.

For more information, see: www.rcm.org.uk/news-views/rcm-opinion/a-warm-welcome/

'Grow your own' nursing workforce development approach: Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust provides mental health and disability services and support across the north of England. In 2013, the trust forecast that over the coming years it would lose many of its registered nurses in mental health and learning disabilities specialities, as a significant proportion would turn 55 and be eligible to retire. Rather than relying on external recruitment of newly qualified nurses to fill the slots, the trust sought to develop and retain members of its existing workforce.

The trust developed a scheme with Sunderland University, validated by the Nursing and Midwifery Council, that enabled a three or four-year nursing apprenticeship for which staff could be released on a part-time supernumerary basis. The introduction of the apprenticeship levy enabled

existing staff to enrol on these apprenticeships and attend university to study nursing, using the levy to pay the funding.

The trust invested in seconding trainees for considerable periods of time, and provided them with laptops to carry out their academic work, on the basis that retention rates were predicted to be higher among staff who were settled in the area and who felt valued and supported by their organisation.

Recruitment for the first cohort began in August 2018. As a result of work from 2014 to equip support staff with National Vocational Qualifications, functional skills and foundation degrees, the trust had more than 150 nursing support workers qualified to enter the new apprenticeship programme. The programme for the first cohort began in January 2019, with no dropouts taking place within the first six months. The trust viewed this as promising, as national dropout rates for university courses tend to be relatively high within the first six months. The trust expects cohorts of between 15 and 20 twice a year for the coming years.

For more information, see:

https://improvement.nhs.uk/documents/6051/CNTW_-_Grow_your_own__a_proactive_approach_to_retaining_nursing_staff.pdf

Clear career pathways: Erskine Care Homes

Erskine is a veteran care charity in Scotland that provides long-term nursing, respite, dementia and end-of-life care across four care homes and a Veterans Village of 44 cottages, an activity centre, five assisted living apartments and 24 single living apartments. Around 500 staff work within the Care Directorate, of which 90 are registered nurses and 5 are allied health professionals.

Erskine has developed an integrated learning and career pathway that is aimed at giving staff a clear sense of the different directions in which their careers could develop within the organisation. There is an emphasis on creating a structured, flexible and dynamic career pathway in which staff are supported to reflect on and pursue the career that they want to take.

Erskine uses career ladder diagrams (such as the one below) to set out the options and routes available, and to help structure developmental

conversations with staff at all levels. Each step up on the ladder requires additional training or qualifications, which Erskine seeks to fund, sometimes working with funding partners. It also seeks to enable staff to work flexibly so they can continue to be employed by Erskine while they undertake development opportunities.



Erskine has a Learning and Development Officer who advises individuals and their line managers on the career paths, development options and support available, and works with the Director of Care, Director of HR and the Chief Executive to access new sources of funding and other support for staff development.

Advice to others

Investing in staff is part of developing a sense of belonging, because it shows you value them. Having a dynamic career pathway helps people feel like they have a future with the organisation. Funding this properly can be difficult, so think creatively about how to find external funding for projects that create posts or training opportunities. Building your profile and network can open up opportunities you wouldn't otherwise get.

(Derek Barron, Director of Care, Erskine Care Homes)

For more information, see: www.erskine.org.uk

Key recommendation 8: Education, learning and development

Ensure that the right systems, frameworks and processes are in place for nurses' and midwives' learning, education and development throughout their careers. These must promote fair and equitable outcomes.

How

Undergraduate nurse and midwifery education

- Institutions providing nursing and midwifery education should establish a key performance indicator for student wellbeing across all learning environments and review feedback to assess performance. This must include an effective feedback mechanism for nursing and midwifery students to speak up about concerns such as bullying either in placements or in education institutions.
- Institutions providing nursing and midwifery education should work collaboratively with students to gather feedback in order to better meet their specific needs in both clinical placements and their studies. This must include measuring and improving student wellbeing and making rapid progress in reducing the high dropout rate among student nurses and midwives.
- Institutions providing nursing and midwifery education and placement providers must undertake assessments and ensure equity for those from minority ethnic groups.
- Where possible, institutions providing nursing and midwifery education must ensure a culture of interdisciplinary learning within the faculty and integrate wellbeing, compassion, compassionate leadership, MDT working and team leadership into education programmes.
- Institutions providing nursing and midwifery education should work in close partnership with placement providers to ensure that they are well-prepared to receive students.

Post-registration

- Leaders across the four UK countries should develop strategies to better support the ongoing development of all nursing and midwifery staff. This should establish new ways of working to improve the capacity and confidence of newly registered nurses and midwives.

- All employers should ensure that newly registered nurses and midwives have a robust and effective period of a minimum of six months' preceptorship when they commence their role.
- There is an urgent need to develop and implement an annual staff survey across primary and social care in all four countries of the UK to augment the four UK country surveys in secondary care. This will provide intelligence on and aid further improvements in care quality and staff wellbeing throughout nurses' and midwives' careers in all settings.
- Employers should review the experiences of nursing and midwifery staff coming to work in the UK from other countries and continually act to better develop and support this group. Targeted support should be provided for international nursing and midwifery staff starting work in the UK health and care system for the first time.

Later career

- Leaders across the four UK countries should develop strategies to ensure the retention of experienced nursing and midwifery staff in health and social care via new career pathways and role development.
- There is a significant need for teaching, training, mentoring and support for nurses and midwives and for developing MDT working that can be provided by more experienced nurses and midwives. Programmes should enable experienced nursing and midwifery staff to continue to contribute without doing only patient-facing work and in a way that reduces the impact of shift work. This should reflect their changing needs as well as reaping the potential benefits of passing on experience to support those at earlier stages of their career.

5 Conclusion

The UK's health and social care services should be models for the world in creating workplaces that promote nurse and midwife wellbeing, through meeting their core work needs.

It cannot be right that a system focused on improving the health and wellbeing of all damages the health and wellbeing of so many. More than 700,000 nurses and midwives working in health and social care are subject to work conditions that in many cases will damage their physical and mental health and wellbeing. It has led to a situation where stress levels are at an all-time high, staff vacancies are creating unmanageable pressures in the system, and sickness absence is more than double what it is in the private sector. It is wrong and unsustainable.

This is a moral issue but is also inconsistent with the core purpose of the services, which is to ensure the health and wellbeing of our populations. The health and wellbeing of nurses and midwives is critical to the quality of care they can provide for patients and communities. It is also an issue of productivity and efficiency to drive the best value for the money spent on health and care. Caring for staff means better outcomes for patients, lower costs and more compassion for all.

A central theme of this report has been the importance of compassion and kindness in interactions between colleagues, between leaders and those who they lead, and between nursing and midwifery staff and the people they care for. There is a convincing evidence base for the beneficial effects of compassion on patient outcomes and the wellbeing of health and care professionals. Neglect, incivility, bullying and harassment of staff have quite opposite effects (Pearson and Porath 2009). There is a core value of compassion in effective teams and organisations, which fosters integration, nurtures trust and respects the emotional lives of members. In such organisations, nurses and midwives become more competent, confident and empowered.

Understanding and helping improve the work environments for nursing and midwifery staff, in service of improving the health and wellbeing of the people of the four UK countries, is an essential and urgent imperative. All health and

care service leaders have a duty to create the cultures that the health and care system needs for the future by practising the skills of compassionate and inclusive leadership. If health and care organisations are founded on the values and cultures of compassion and inclusion, they will foster individual, team, inter-organisational, and community wellbeing characterised by fairness, trust, thriving and wellbeing.

In that way, nurses' and midwives' needs for autonomy, belonging and contribution at work can be met, thereby contributing to the wellbeing of patients and communities across the UK. That should be a solemn commitment from all, honouring the sacrifice and courage of nurses and midwives during the pandemic and throughout their careers.

Appendix 1: Full list of recommendations

No single organisation can deliver the changes recommended in this report. To achieve the necessary improvements there must be shared ambition and renewed collaboration among the main national agencies, governments, regulators and employers across the four UK countries. Supporting the health, wellbeing and flourishing of nursing and midwifery staff requires action at every level of the health and care system.

Leaders of health and care organisations should monitor progress against the recommendations through the establishment and use of robust, reliable data and key performance indicators. They should also seek and review feedback from staff to assess and improve their performance. These efforts should be supported by systems regulators, improvement bodies and other partners, who should check that organisations are using appropriate mechanisms to track and improve performance in each area identified in the recommendations, and who should help share learning and good practice.

We urge those responsible for the employment, leadership, support and regulation of nursing and midwifery staff to act together wherever they can to ensure the implementation of each and all the recommendations. Transforming the work lives and lived experience of nursing and midwifery staff, and thereby the quality and sustainability of the care they provide, requires that we implement an integrated, coherent and effective strategic approach.

Key recommendation 1: Authority, empowerment and influence

Introduce mechanisms for nursing and midwifery staff to shape the cultures and processes of their organisations and influence decisions about how care is structured and delivered.

- i. Leaders should ensure that there are effective means to enable nursing and midwifery staff at all levels to shape decisions, policy, practice, work processes and culture in their organisations.
- ii. Leaders should ensure that there are means to evaluate the response to the concerns nursing and midwifery staff raise and ensure a focus on listening, learning and compassion, and not on blame.
- iii. All organisations must work to ensure that the level of voice and influence experienced by staff from minority ethnic groups is equivalent to that of the other staff in their organisations.
- iv. The nursing and midwifery professions should begin a consultation process on how to create flatter structures, better enable teamworking and encourage an ethos that places greater value on contribution than on hierarchy.

Key recommendation 2: Justice and fairness

Nurture and sustain just, fair and psychologically safe cultures and ensure equity, proactive and positive approaches to diversity and universal inclusion.

- i. Health and care leaders must continue to review and reform as appropriate structures and processes such as appointment and promotion processes, disciplinary procedures, and complaints handling.
- ii. All health and care organisations should implement a strategic approach for achieving culture change in relation to the experience of minority ethnic group staff. Equity of experience for minority ethnic group staff must be achieved in relation to each of the eight broad recommendations in this report.
- iii. Health and care cultures must be changed through leadership practice, leadership development and teamworking interventions so that everyday discrimination does not go unchallenged. The overall aim must be to ensure that positively diverse and universally inclusive behaviours are modelled and practised at every level of the health and care system.
- iv. All health and care leaders must work to create cultures characterised by psychological safety, with a focus on learning rather than blame, thereby increasing the pool of nursing and midwifery knowledge, creative ideas and experience available to decision-makers overseeing health and care organisations.

Key recommendation 3: Work conditions and working schedules

Introduce minimum standards for facilities and working conditions for nursing and midwifery staff in all health and care organisations.

- i. All health and care employers should provide all nursing and midwifery staff with places, time, and a sense of the right and necessity to rest and, where appropriate, sleep. In appropriate settings, employers should ensure access to bathroom facilities and nourishing food and drinks (including basic hydration).
- ii. Pay is a dissatisfier for nurses and midwives, given their expertise, contribution and commitment. They must be appropriately remunerated for their work.
- iii. All health and social care organisations must take effective measures to protect nursing and midwifery staff from violence, threats of violence, harassment, bullying and abuse.
- iv. Nursing and midwifery leadership, national bodies and leaders of every organisation employing nursing and midwifery staff should review facilities and produce guidance for nursing and midwifery staff to ensure compliance with wise, evidence-based management of fatigue and facilities.
- v. All employers should implement work schedules and rotas based on realistic forecasting that supports safe shift-swapping, enables breaks, takes account of fatigue, and involves nursing and midwifery staff with knowledge of the specialty to consider the demands that will be placed on them.
- vi. Assessments should be regularly undertaken to ensure that staff from minority ethnic groups are not disadvantaged relative to other staff in relation to working conditions.
- vii. The nursing and midwifery professions should undertake a courageous, comprehensive and transparent joint review of the impact of 12-hour shifts on their mental health and wellbeing, on capacity for earnings, and on care quality and safety. The review should investigate the full range of alternatives such as the use of hybrid shift systems. The review should also explore how to mitigate any negative impacts of the current system of 12-hour shifts on staff wellbeing and care quality and safety.

Key recommendation 4: Teamworking

Develop and support effective multidisciplinary teamworking for all nursing and midwifery staff across health and care services.

- i. All health and care organisations should regularly review teamworking and ensure that all nursing and midwifery staff are working in inclusive, stable, effectively functioning and, ideally, multidisciplinary teams freed from unnecessary hierarchical or interprofessional constraints.

ii.	All teams should have an openly stated shared purpose and clear objectives, one of which is team member wellbeing. Team members should be clear about their roles and responsibilities. Quality improvement should be a core function of all teams.
iii.	All teams should meet at least monthly to review and reflect on their performance, including inter-team/cross-boundary working, and to develop ideas for improved ways of working to ensure high-quality care and staff wellbeing.
iv.	Teamworking and team leadership skills should be a fundamental part of all nursing and midwifery appraisal and revalidation processes. Team education and training and team leadership opportunities should be embedded within every health and care course curriculum and within continuing education programmes for practising nurses and midwives.
Key recommendation 5: Culture and leadership	
Ensure that health and care environments have compassionate leadership and nurturing cultures that enable both care and staff support to be high quality, continually improving and compassionate.	
i.	All health and care organisations should implement a programme of compassionate leadership support and development.
ii.	This should include mechanisms to ensure that nurse leaders and other leaders of nursing and midwifery staff at all levels in the health and care system are recruited, selected, developed, assessed and supported to model compassionate and inclusive leadership.
iii.	Assessments should be employed to determine whether staff from minority ethnic groups experience leaders who are less compassionate and inclusive than other staff, and developmental supports put in place to close the gaps for such leaders.
iv.	Compassionate leadership training and assessment should be part of all educational interventions at undergraduate, post-registration and later career development programmes and should be included in NMC education standards. Leadership development programmes should be diverse and inclusive to ensure that future leaders are reflective of the wider staff and populations they serve.
v.	All health and care organisations should regularly review their cultures and ensure that they are continuously developing cultures of high-quality, continually improving and compassionate care for patients, and high-quality, continually improving and compassionate support for staff.

Key recommendation 6: Workload

Tackle chronic excessive work demands in nursing and midwifery, which exceed the capacity of nurses and midwives to sustainably lead and deliver safe, high-quality care, and which damage their health and wellbeing.

- i. All organisations that oversee the work of nursing and midwifery staff must continually undertake, in collaboration with nursing and midwifery staff, a programme to review workload in their organisations.
- ii. Assessments should be conducted to determine whether staff from minority ethnic groups experience higher levels of chronic excessive workload than other staff, and developmental supports put in place to ensure equity.
- iii. Initiatives under way across the UK to increase staffing numbers must be reinforced, given the large number of vacant posts.
- iv. A variety of approaches to addressing workload must be undertaken in concert, including the following.
 - Programmes to deploy and develop alternative roles, such as administrative support staff and maternity support workers, to enable nursing and midwifery staff to work at the top of their competency, supported by effective MDT working in all areas of health and care.
 - A continual review of tasks, activities and processes that do not add significant value either to patient care or staff wellbeing.
 - A continual review of new technologies being used in UK health and care systems to increase efficiency and reduce workload.
 - A programme of continuous process improvements (using quality improvement approaches) especially through collective discussion in regular team meetings.
 - Well-trained staff to lead in engaging communities, community representatives and patients in taking shared responsibility for their health and care services.

Key recommendation 7: Management and supervision

Ensure that all nursing and midwifery staff have the effective support, professional reflection, mentorship and supervision needed to thrive and flourish in their roles.

- i. All organisations that employ nursing and midwifery staff should ensure that each has an appropriately trained line manager supporting them to work and develop effectively, providing regular one-to-one review meetings and ensuring their work needs are met. There should be particular support for newly registered nurses and midwives.
- ii. Management, support, educational and clinical supervision should be included in the job plans of line managers and clinical supervisors, and their workloads balanced to ensure that they have protected time to provide these functions.
- iii. Line managers should receive professional development to ensure that they have the necessary skills, confidence and compassionate and inclusive leadership behaviours to offer nursing and midwifery staff the support they need to be effective.

Key recommendation 8: Education, learning and development

Ensure that the right systems, frameworks and processes are in place for nurses' and midwives' learning, education and development throughout their careers. These must promote fair and equitable outcomes.

Undergraduate nursing and midwifery education

- i. Institutions providing nursing and midwifery education should establish a key performance indicator for student wellbeing across all learning environments and review feedback to assess performance. This must include an effective feedback mechanism for nursing and midwifery students to speak up about concerns such as bullying either in placements or in education institutions.
- ii. Institutions providing nursing and midwifery education should work collaboratively with students to gather feedback in order to better meet their specific needs in both clinical placements and their studies. This must include measuring and improving student wellbeing and making rapid progress in reducing the very high dropout rate among student nurses and midwives.
- iii. Institutions providing nursing and midwifery education and placement providers must undertake assessments and ensure equity for those from minority ethnic groups.
- iv. Where possible, institutions providing nursing and midwifery education must ensure a culture of interdisciplinary learning within the faculty and

	integrate wellbeing, compassion, compassionate leadership, MDT working and team leadership into education programmes.
v.	Institutions providing nursing and midwifery education should work in close partnership with placement providers to ensure that they are well-prepared to receive students.
<i>Post-registration</i>	
i.	Leaders across the four UK countries should develop aligned strategies to better support the ongoing development of all nursing and midwifery staff. This should establish new ways of working to improve the capacity and confidence of newly registered nurses and midwives.
ii.	All employers should ensure that newly registered nurses and midwives have a robust and effective period of a minimum of six months' preceptorship when they commence their role.
iii.	There is an urgent need to develop and implement a staff survey across primary and social care in all four countries of the UK to augment the four UK country surveys in secondary care. This will provide intelligence on and aid further improvements in care quality and staff wellbeing throughout nurses' and midwives' careers in all settings.
iv.	Employers should review the experiences of nursing and midwifery staff coming to work in the UK from other countries and continually act to better develop and support this group. Targeted support should be provided for international nursing and midwifery staff starting work in the UK health and care system for the first time.
<i>Later career</i>	
i.	Leaders across the four UK countries should develop strategies to ensure the retention of experienced nursing and midwifery staff in health and social care via new career pathways and role development.
ii.	There is a significant need for teaching, training, mentoring and support for nursing and midwifery staff and for developing MDT working that can be provided by more experienced nursing and midwifery staff. Programmes should enable experienced nursing and midwifery staff to continue to contribute without doing only patient-facing work and in a way that reduces the impact of shift work. This should reflect their changing needs as well as reaping the potential benefits of passing on experience to support those at earlier stages of their career.

Appendix 2: Methodology

Aims and scope

This report investigates the changes that are needed to nurses' and midwives' workplaces and ways of working to enable them to flourish at work and to support them to provide compassionate, high-quality care in a sustainable manner.

The report:

- identifies a set of key workplace factors that have an impact on the wellbeing of nursing and midwifery staff, including organisational cultures, working environments and leadership styles
- explores the impact that these factors have had on nurse and midwife wellbeing, both before and during Covid-19
- examines the consequences of low wellbeing for nursing and midwifery staff themselves, their colleagues, their organisations and their patients
- recommends changes in relation to each of the factors to better support the wellbeing of nursing and midwifery staff and to enable them to thrive at work
- uses examples of good practice to demonstrate what progress against each of the factors might look like.

The scope of the report covers all nursing and midwifery staff and students, including healthcare assistants and nursing associates. It spans all four UK countries, all types of employer (including NHS, GP practice, local authority and independent sector), and all care settings where these nursing and midwifery staff operate: primary care, secondary care, mental health, community care and social care.

It covers all areas of practice, including (but not limited to) midwifery, primary care, community, health visiting, public health, mental health, nursing home, learning disability, neonatal, occupational health, e-health, children and young people, management, cancer care, rehabilitation.

Approach

This report is based on evidence gathered through a literature review, secondary analysis of quantitative data, semi-structured interviews and focus groups.

Literature review

A literature review was conducted focusing on: the current picture of nurse and midwife mental health and wellbeing across the four UK countries; the evidence on the key causal factors that have an impact on nurse and midwife mental health and wellbeing; the impact of low wellbeing levels on staff, organisations and patients; and national and international evidence around primary interventions aimed at improving nurse and midwife mental health and wellbeing. Primary interventions were defined as interventions aimed at modifying or eliminating stressors in the work environment that could have an impact on an individual's health and wellbeing. Five databases were searched for published literature: British Nursing Index (BNI), CINAHL, HMIC, Koha and MEDLINE. In addition to the database searches for published literature, academic and practice experts were contacted for advice on publications that were relevant to the scope of the review. The team did not conduct a systematic review of literature due to the limited timescale for the review.

Quantitative analysis

The review team conducted secondary analysis of publicly available data from: NHS England's 2019 Staff Survey; the 2018 NHS Wales Staff Survey; the Scottish government's iMatter Staff Experience Continuous Improvement model 2019; NHS Scotland Workforce Statistics at 31 March 2020 from National Education Scotland; the 2015 Health and Social Care Northern Ireland Staff Survey; NHS Digital Workforce Statistics from April 2020; the NHS Workforce Race Equality Standard Data Reporting 2019; Skills for Care's report, *The size and structure of the adult social care sector and workforce in England, 2020*; the National Audit Office's 2018 report, *The adult social care workforce in England* and *The NHS nursing workforce* report 2020; the NMC Register and Leavers' Survey 2019; and the RCN Employment Survey 2019. The data was used to explore trends in staffing numbers and indicators of wellbeing, including engagement, satisfaction, stress, sickness absence and presenteeism, and to understand how workplace factors might have an impact on the wellbeing of nursing and midwifery staff.

Interviews

In total, 47 semi-structured interviews were conducted across the four UK countries. Interviews were conducted by video conference or by telephone. Notes were taken either by the interviewer or by a note-taker who observed the interview.

We spoke to a wide range of stakeholders, including:

- nursing and midwifery staff at a range of levels of seniority and across the acute sector, mental health, primary care, community care, social care and the independent sector
- nursing and midwifery students and undergraduate nursing and midwifery education bodies
- representative bodies and royal colleges
- postgraduate nurse and midwifery education bodies
- government departments in each UK country
- HR and workforce leaders at organisational, regional and national levels
- national bodies overseeing health and care services
- regulators and improvement bodies
- academics and researchers.

A comprehensive list of organisations that the review team met with is provided in Appendix 3.

Interviewees were asked to share their perspective on the key factors that have an impact on nurse and midwife wellbeing, their views on what actions needed to be taken to achieve positive change, and examples of good practice that could be adapted and used more widely.

Some interviews were used to inform the examples of good practice highlighted in the report. These interviewees were asked for details on the approach being shared, the outcomes and impact of that approach, and any lessons that have emerged. Later-stage interviews were used to sense-check emerging findings and recommendations. In most cases, written material was shared for discussion before these interviews, and written feedback was received.

Notes were taken in each interview. The data from these interviews is shared in the report in a non-attributable manner, except in cases where proper permission to share attributable data was given.

Focus groups

Three 90-minute focus groups were carried out with a total of 13 nursing and midwifery staff. These were conducted by video conference. Two members of The King's Fund staff took part, with one facilitating the conversation and one taking notes.

The sampling was intended to ensure that the review team heard from a diverse range of perspectives, rather than to be representative of the group covered by the scope of the review. A call for participants was put out through the Transforming Perceptions of Nursing and Midwifery ambassador network, members of which circulated the call for participation among their colleagues. Participants were selected with a view to ensuring a diverse range of levels of seniority, professions, geographical locations and care settings.

The sessions were structured in 'rounds' in which each participant had an equal amount of protected time to speak, with two rounds per question so that people could respond to each other's comments. The questions explored what participants saw as the key workplace factors that have an impact on their mental health and wellbeing, the impacts of the Covid-19 pandemic on these workplace factors, where changes were most needed to support nurse and midwife mental wellbeing, and what they thought positive change could look like in practice. Participants were invited to follow up the session with further reflections and comments through correspondence with the research team.

The sessions were recorded. Data collected from the focus groups was used in the report in a non-attributable manner.

Appendix 3: List of organisations consulted

We spoke to nursing and midwifery staff at a range of levels of seniority and across the acute sector, mental health, primary care, community care, social care and the independent sector, across the four UK countries, as well as nursing and midwifery students, academics and researchers, and HR and workforce leaders at organisational, regional and national levels.

In addition to this, we spoke to stakeholders from the following organisations:

- All4Maternity
- C3 Collaborating for Health
- Council of Deans of Health
- Department of Health Northern Ireland
- Florence Nightingale Foundation
- Foundation of Nursing Studies
- Health Education England
- Health Education and Improvement Wales
- Mandy Ashton Consultants Limited
- National Workforce Skills Development Unit
- NHS England and NHS Improvement
- Nursing and Midwifery Council
- The Queen's Nursing Institute
- The Queens Nursing Institute Scotland
- RCN UK Student Committee
- Royal College of Midwives
- Royal College of Nursing
- Scottish Government

- Skills for Care
- Unite the Union
- WeStudentNurses
- Welsh Government.

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He led the Department of Health Policy Research Programme into cultures of quality and safety in the NHS in England from 2009 to 2013. He also led the NHS National Staff Survey development and implementation for eight years. He assisted Health Education England and NHS Improvement in developing the national framework on improvement and leadership development in England (*Developing People, Improving Care*) and the Department of Health in Northern Ireland in developing the Collective Leadership Strategy for Health and Social Care (2017). He co-chaired, with Dame Denise Coia, the two-year inquiry on behalf of the UK General Medical Council into the mental health and well-being of doctors *Caring for Doctors, Caring for Patients*. He is currently supporting Health Education and Improvement Wales to develop the national NHS leadership strategy in Wales.

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