Nursing Minds

A response to the escalating concerns about nurses' mental health and wellbeing

February 2021

Introduction

Mental health related sickness absence is the biggest cause of nurses being absent from work because of illness/ill health in England, Scotland and Wales and the second biggest cause in Northern Ireland. C3's nursing programme aims to develop strategies to promote the wellbeing of the nursing workforce. Our ongoing work to address the healthy weight of nurses has led to the significant consideration and analysis of nurses' mental wellbeing.

In 2020 commentary describing concerns about nurses' mental health and wellbeing had reached a crescendo. A review of the literature describing the poor mental health and wellbeing of the nursing workforce was conducted by the Society of Occupational Medicine in 2020 – *The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom*[1]. The breadth of literature reviewed highlights the significant work that has been undertaken to identify that nurses' mental health is a real issue. However, in contrast, not enough has been done to actually address the issue. Little progress has been made in taking forward the sound recommendations from Steve Boorman's 2009 *NHS Health and Well-being review*[2] – the *Boorman Review.*

The danger of ignoring the *Boorman Review* findings was evidenced in 2013, when the findings of the Francis inquiry – an inquiry into the failures of care at Mid Staffordshire NHS Foundation Trust – revealed that staff wellbeing had not been adequately recognised or indeed acted upon. Commercial companies had already acknowledged staff wellbeing as being critical to success and subsequently a workplace health industry was growing rapidly – but the NHS appeared to still be taking staff wellbeing for granted.

A decade later, progress has continued to be slow and the dangers of ignoring staff wellbeing are with us again. Like the *Boorman Review* of 2009, the publication in 2019 of the *NHS Staff and Learners' Mental Wellbeing Commission*[3] – the *Pearson Report* – is another well researched commentary on how a caring and compassionate NHS should demonstrate and reflect these values as an employer in caring for its staff. However, once again, its recommendations have not yet been fully implemented. In 2020 The *Courage of Compassion* report[4], published by the King's Fund, catalogued the breadth of the problem and called for action on its recommendations.

Interview findings and key recommendations

The analysis of the policy landscape involved 15 semi-structured interviews with key thought leaders that explored the barriers to supporting nurses' mental health, and how evidence-based recommendations may be implemented. The most overwhelming observation to emerge from this

scrutiny of nurses' mental health and wellbeing, and the policy environment is the persistent failure of the health community to act on previous relevant analysis and recommendations that have endeavoured to address the problem of how to support the nursing workforce and facilitate wellbeing. The evidence of this exists in the outputs of the 2009 *Boorman Review* that included a set of twenty recommendations that remain as relevant today as they did in 2009 – but have still not been properly implemented.

The analysis of the interview data addressed 12 themes. A detailed analysis of interview data and themes can be found in appendix 1; nursing and health leader interviewees are listed in appendix 2.

Two recommendations have emerged from the thematic analysis of interview data, they include:

- To acknowledge and learn from the failure to act on previous analysis and recommendations.
- To use three new system drivers of change:
    - 1. COVID-19
    - 2. The NHS People Plan
    - 3. The NHS Staff and Learners' Mental Wellbeing Commission

Recommendation 1:

To acknowledge and learn from the failure to act on previous analysis and recommendations

The evidence of the semi-structured interviews suggests that the recommendations in the *Pearson Report* (2019) around NHS board leadership of mental wellbeing have not been fully realised in the service nearly two years – and a worldwide pandemic – later. The health system cannot afford to squander the opportunity to fully enact the levers for change described in the *Pearson Report*. Unless action is taken and recommendations are implemented, it risks being perceived as part of a culture that has allowed mental health related sickness absence to become the dominant reason for nursing sickness absence.

This acknowledgement should also create anxiety around the delivery of commissioned reviews and reports in the future – they must be delivered carefully so that they have a positive and significant impact on the nursing workforce. The *Courage of Compassion* report is a case in point. Despite being well researched and written, and containing an implementation plan, the health community must find a way of leveraging its delivery so that it doesn't fall by the wayside.

The nursing community needs to acknowledge this, and signal to the wider health community that it has recognised and acknowledged that change must happen.

Recommendation 2:

To use the new system drivers of change

The commentary from the semi-structured interviews with leaders and change-makers focused on three critical factors: COVID-19; the *NHS People Plan*; and the *NHS Staff and Learners' Mental Wellbeing Commission*, which have the potential to secure the traction needed to deliver different outcomes.

1. **COVID-19**

The first observed new driver of change is the impact of COVID-19 on the NHS and its ability to innovate around staff engagement and wellbeing. In its response to COVID-19, the NHS has

demonstrated that it can be nimble in introducing change, and immensely capable in learning better ways to support its nursing workforce especially when that workforce has been at its most vulnerable. This response has also been ethnically sensitive and appropriate in its ambitions – which has enhanced its integrity. If it can maintain the momentum, the response can be the vehicle through which the NHS can demonstrate to its nursing staff that it understands and is responsive to its needs. COVID-19 has enabled changes to the way staff work and has generated new behaviours.

The courageous voices of individual nurses describing how their employers let them down with inadequate personal protective equipment (PPE) at different points during the pandemic are just as important in helping embed change as are NHS Trust chairs and CEOs having the courage to change their own organisational behaviours that have previously (albeit unintentionally) sabotaged staff wellbeing initiatives.

The voices of Dame Donna Kinnair of the RCN and the four UK Chief Nursing Officers championing their workforces during the pandemic reminded nurses that concerns about their wellbeing were being listened to, actioned and converted into specific interventions to ameliorate the profound impact of their work on their wellbeing. If these new skills and responses to adversity and conflict can become the medium through which the NHS negotiates its ownership of the issue and develops its actions in relation to enhancing staff wellbeing, there are grounds for optimism.

2. The NHS People Plan

The second new driver of change to emerge from the interviews is the structure, emphasis and stewardship of the *NHS People Plan*[5] and the leadership commitment being given to its delivery both nationally and locally in England NHS Trusts as part of making the NHS a valued place to work.

The semi-structured interviews revealed respect for how Prerana Issar – the NHS Chief People Officer – is leading evolution of, and engagement with the plan and creating a commentary about its ambitions that impact the mental wellbeing of nurses. The interviewees commented upon the development of alliances that embed the work and give it the visibility and recognition needed to make change happen. National and regional nurse leaders and academics and trade union leaders, alongside NHS Trust nurse directors and their management teams and staff sides, have already started to act on the direction and the specifics of the *NHS People Plan,* and must exploit further the opportunity provided by the momentum it has generated to date. The breadth of the NHS response to the psychological needs of the nursing workforce during the pandemic is to be commended and must be sustained.

The reporting on the progress towards delivery of the *NHS People Plan* at a national level and at local levels and within occupational groups needs to be finessed so that they stimulate dialogue about how an organisation can facilitate mental wellbeing. The way the *NHS People Plan* is drafted enables managers to make this happen, and it facilitates NHS Trust boards and communication teams to use it as a platform on which staff can engage in discussion on mental wellbeing in relation to their employment.

3. The NHS Staff and Learners' Mental Wellbeing Commission

The third new driver of change is the *NHS Staff and Learners' Mental Wellbeing Commission* – the *Pearson Report* – chaired by Sir Keith Pearson and published in February 2019, which creates powerful and precise governance discussions and levers to drive wellbeing at board level across

every NHS organisation. The report specifically identified the vulnerability of nurses to poor mental health and was explicit about the need for NHS board level leadership and responsibility for the mental wellbeing of staff.

The *Pearson Report* calls for the creation of board level 'NHS Workforce Wellbeing Guardians' in every local, regional and national NHS organisation; and anticipates this board level role to be an existing executive director and aligned with a non-executive director. It is envisaged that the role seeks to assure and continue to reassure the board that their organisation is a wellbeing organisation and a healthy workplace in which NHS staff and learners can work and thrive. The role would be responsible for ensuring sufficient intelligence reaches the board to enable it to benchmark, set organisational expectations and monitor performance. The review outlines nine NHS Workforce Wellbeing Guardian principles to assure the work.

Interviewees suggested that whilst these roles have been identified in many NHS Trusts, they have yet to be empowered sufficiently in NHS board rooms to realise their potential to fundamentally change the way the NHS delivers on nursing staff wellbeing. Whilst some of the focus and drive around the work was evident in the COVID-19 activity, it appears that the roles have yet to be delegated the authority that the *Pearson Report* envisages for them – an authority that the NHS needs its directors to harness and use to drive change and hold the service to account around mental health related nurses' sickness absence. The NHS still has an opportunity to fully realise these roles as a conduit for nursing staff engagement around wellbeing issues and the NHS needs to be held to account on their delivery and make them visible and accessible to the workforce.

Concluding remarks

We thank the Burdett Trust for Nursing for funding this work addressing the mental wellbeing of the nursing community. Over the past five years C3 has undertaken a programme of work around the neglected area of the wellbeing of nurses. It has been the generosity of the Burdett Trust that has significantly enabled this work.

We also wish to express our thanks to those whose input has shaped this project: the nursing and health leaders who agreed to be interviewed and the project steering group members. That these contributions were delivered in the context of the pressures of a world pandemic is especially appreciated.

We hope that this report will in some way also reduce the stigma and shame some nurses experience surrounding the disclosure of a mental health problem, and that it reduces the fears some registrants have around regulatory responses to their disclosure of mental health issues. We wish the nursing profession well in getting better and better at continually enhancing its own mental health and wellbeing. We wish the NHS and other UK health providers well in facilitating and delivering improvements.

References

1. Kinman G, Teoh K, Harriss A. *The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom*; 2020.
2. Boorman S. *NHS Health and Well-Being Review*; 2009.
3. Health Education England. *NHS Staff and Learners ' Mental Wellbeing Commission*; 2019.
4. West M, Bailey S, Williams E. *The Courage of Compassion Supporting Nurses and Midwives to Deliver High-Quality Care*; 2020.
5. NHS. *WE ARE THE NHS: People Plan for 2020/2021-Action for Us All*; 2020.

Appendix 1

Analysis of interview data

The semi-structured interviews with 15 nursing and health leaders addressed the following themes:

- The significance of the Boorman Review recommendations
- The association between staff wellbeing and organisational performance
- The implementation of strategies and access to interventions
- Management ownership of wellbeing and related management training
- Supporting staff with mental health problems
- COVID-19
- The role of trade unions and professional associations
- Learning from innovation
- Regulatory mechanisms
- Accountability, inclusion and wellbeing
- Impact of the 2019 NHS Staff and learners' Mental Wellbeing Commission
- Support for the Courage of Compassion principles

The significance of the Boorman Review recommendations

To re-read the *2009 Boorman Review* recommendations in 2020 is a salutary exercise. They are as relevant, compelling and as contextually appropriate as they were when they were first published over a decade ago.

One of the strongest observations to emerge from the interviews in terms of changing the policy landscape was the perceived failure of the health community to properly implement the Boorman recommendations in the NHS in England in 2009, and the legacy this shaped in terms of the ongoing neglect of nurses' mental health and wellbeing.

The association between staff wellbeing and organisational performance

Boorman suggested that all NHS managers should be developed to recognize the association between staff health and wellbeing, and the performance of an organisation, and that NHS managers should be judged on their contribution to staff wellbeing. Interviewees believed that a decade later this recommendation is still inadequately implemented, poorly managed and not measured. Interviewees described leadership and development training as too focused on operational and transactional issues and lacking in guidance on how to manage and sustain employee wellbeing. What the NHS has not sufficiently discussed, and hence what its managers lack and therefore do not value, are skills in how to manage conversations that explore how individuals are coping. Interviewees described an over reliance on the application of specific processes rather than understanding how to discretely and compassionately support staff wellbeing, which is currently under scrutinised.

The interview data included observations about NHS board discussions that relate to compassion. Interviewees identified that board discussions can lack dialogue around the appropriate conditions of the organisation that they, as governors, need to ensure are developed so that patients and staff routinely experience compassion and respect. This curtailed the appropriate consideration of what type of organisation board members must design and deliver.

The implementation of strategies and access to interventions

In 2009 Boorman also addressed the need for NHS trusts to identify the major health issues affecting their staff and highlighted a duty of care to implement strategies to counter these issues. The interviews suggest that employers' failure to address mental health related sickness absence needs calling out again in 2021. Both the extent of mental health related sickness absence and the inadequacy of the service response to date suggest a major failing in employers' duty of cere. One interviewee also commented on the added difficulty of re-entering the nursing workforce after an episode of mental illness.

However, there was also some positive evidence of action, which lay in the increasing interest in, and delivery of, initiatives such as Schwartz rounds as a means of tackling the emotional strain of caregiving. The initial adoption of Schwartz rounds was triggered by the Mid Staffordshire Hospital enquiry and its findings that related to the negative impact of consistent exposure to stress on clinicians' focus and concentration.

The emergence of NHS wellbeing leads was also referenced by some interviewees. Such roles have been generated in order to identify and deliver remedial actions such as restorative supervision to counter workplace stressors – although this role was not perceived as standardised or routine, and it appears that it is not yet properly embedded or understood to be having any widespread impact. The same applies to the 40 regional mental health and wellbeing hubs currently being implemented across the NHS – it is too early to assess their impact on the mental health related sickness absence of the nursing workforce, but our nursing leaders must be aspirational in relation to the expectations of these potentially high impact resources. Such interventions have been driven by the new *NHS People Plan.* Whilst the plan wasn't frequently cited enough during the interviews for it to be safe to assume that it is already shaping managerial and leadership behaviours sufficiently in this area, it's clarity of direction on wellbeing is a potential game changer.

There were references made to the first wave of the COVID-19 pandemic, where interviewees cited frank discussions that went on with employers, NHS E/I, trade unions, equality leads and a range of other people about beginning to understand why it was that black and minority ethnic clinicians were dying in the ways that they were. The manner in which this dialogue was welcomed in the face of adversity is important given the lack of action around escalating evidence of poor mental health and wellbeing in the nursing workforce.

A parallel was drawn between Black Lives Matter and race trauma and nurse's mental health and wellbeing. An interviewee talked about everyday discrimination, and how one just learns to live with it, but that the cumulative effect of this kind of 'weathering' is an issue that BME nurses have been dealing with for some time and is one which undermines their mental health and wellbeing. A parallel was drawn between the inappropriate expectation that BME nurses should be reliant on this idea of resilience to deal with racism and the inappropriate expectation that nursing collectively should be resilient to deal with unreasonable workplace stressors. Interviewees noted the ease with which organisations will talk to people about being resilient, which is welcome, but that they often then ignore the workplace factors that damage resilience. They noted the need for employers to be more ambitious in identifying the sources of harm and apply the controls needed to mitigate these. They observed an absence of questions being asked about whether NHS processes are safe, and about whether the way in which people experience the organisation is one that's designed to produce wellbeing?

Interviewees observed with frequency that the implementation of preventative strategies in NHS organisations was lacking. However, it was noted that when they were developed and implemented, they could be powerful in maintaining wellbeing. An example cited was at Barts Health NHS Trust, where a dedicated member of staff followed-up nurses involved in traumatic clinical events. This was not only seen as valuable in preventing Post Traumatic Stress Disorder (PTSD), but also as evidence of an employer demonstrating very specific awareness and understanding of nurses' work.

The semi-structured interviews explored the evidence of NHS Trusts facilitating consistent access to early intervention strategies for nursing staff with mental health related problems. Responses to this issue fell clearly into pre- and post-COVID-19. Apart from references to PTSD prevention interventions in NHS Trusts like Nottingham University Hospitals NHS Trust, Mersey Care NHS Foundation Trust, and Barts Health NHS Trust – and references to very promising work across increasing parts of the ambulance service – there was limited reference to specific initiatives before the pandemic. These interventions clearly escalated as a result of the pandemic. They were seen by interviewees as one of the success stories of the NHS COVID-19 response and are recognised as important and valuable dimensions of the NHS response to the mental wellbeing of staff that must be sustained.

Management ownership of wellbeing and related management training

In 2009 Steve Boorman was very clear that health and wellbeing in the NHS workplace needed to be owned by managers and that they should be judged on whether they actually made a contribution to staff wellbeing. He observed that the most frequently cited reasons for the poor adoption of wellbeing recommendations is that they are not owned in practice by managers and that conversations about staff wellbeing at work are not hardwired into managers work. This could lead, for example, to a nurse coming back from six weeks off sick with depression and his/her line manager not having a conversation with that individual about what that depression meant to them and to their work.

Interviewees observed that managerial ownership of the issue is starting to be better facilitated. They observed more learning and development support for managers, so that they know what to do when they hear this information and avoid it being embarrassing or intrusive – but given the increasing prevalence of mental health related sickness, this still is not translating into sufficient or effective workplace strategies.

Management behaviours – and especially fairness – were seen by interviewees as key shapers of wellbeing and openness to change in a given team or workforce. Interviewees cited HSE stress standards – and their focus on whether an individual feels they are treated fairly in the workplace – as an organisational aspect of mental health and wellbeing that managers are well placed to realise and facilitate. Managerial understanding about mental health was acknowledged to be under-developed, as was the need for managers to role model managing their own mental health. Interview data identified that promoting the health and wellbeing of the nursing workforce needs to be an integral part of management training at all levels in the NHS. Interviewees also believed that this extended to appraisals, which are currently over focussed on performance, at the expense of discussions around wellbeing.

The impact of the COVID-19 pandemic, and its influence on promoting the nurses' wellbeing agenda and making it integral to management and leadership training at all levels in the NHS was positively acknowledged by interviewees. A belief was expressed that the pandemic cannot leave nursing leadership unchanged. The fact that nurses and doctors died exposed the need to invest more rigorously in how to support and organize a cohort of skilled professionals to deliver care at

their highest level of productivity. Good and readily accessible occupational health support was viewed as critical to shaping this change.

There was concern however that there were not enough conversations taking place and that with the exception of the *Courage of Compassion* report and its welcome adoption of compassionate and inclusive leadership tenets – there is no readily observable theory of change emerging in the nursing profession around how to deliver these changes, and there is currently not enough nursing scholarship addressing this deficit.

It was noted that the NHS can focus on supporting the workforce to work at its highest level of productivity and flu vaccinations were cited as an example of this. Interviewees reflected that over recent years a successful focus had been created amongst nurse managers on whether staff have received their annual flu vaccination. Interviewees noted that the same attention is not routinely focussed on promoting mental wellbeing amongst staff, and the response to flu was seen as an example that could be translated into other areas such as mental health. It was also noted that flu vaccination had been incentivised in the NHS and whether similar methods of changing managerial behaviour could be adopted to finesse the management of mental wellbeing.

Supporting staff with mental health problems

Interviewees discussed whether or not there was evidence to ensure managers have the skills and the tools to support staff with mental health problems. The work of the NHS Leadership Academy was deemed to be relevant in developing inclusive leadership, and the capabilities and skills required for managers to engage in issues with staff that they may not have previously engaged in before. Conversations about wellness were perceived as being in this space, however it was observed that there is not sufficient push or pull to engage managers in looking at staff mental health differently.

The NHS Leadership Academy is explicit that engagement between managers and staff is a process of discovery that requires managers to engage in ambiguity and to find out things that they perhaps didn't understand before, and this means acknowledging issues that they had not previously identified, and to feel equipped to deal with what emerges. However, it was felt that not enough managers were undergoing this training, but the new *NHS People Plan* was perceived to have the potential to address this deficit.

The interviews explored the risk assessment and identification of mental health related sickness absence amongst nurses as a specific risk within the NHS workforce. This Boorman recommendation was seen as having been especially poorly adopted in England's NHS, and explains the degree of system tolerance for unacceptably high levels of mental health related sickness absence amongst nurses.

COVID-19

Interviewees noted that COVID-19 has given permission to change the ways in which the NHS works and there was a robust recognition, particularly amongst frontline staff, that things must change. Some interviewees had detected a sense of staff feeling under appreciated by their organisation – they may feel appreciated by their colleagues and the public, but that their lived experience of being unconvinced that they could trust their organisation to deliver something as fundamental as adequate PPE at certain points during the pandemic, had generated a shift in their psychological contract with their employer. Some interviewees anticipated that new nurses coming into the NHS workplace would have very different and distinctive expectations about the world of work and what they should expect from an employer and that they don't see a service, or leadership and development training that's ready for these expectations.

The role of trade unions and professional associations

With a few notable exceptions, the interviewees did not observe trade unions and professional organisations as being sufficiently ambitious in their engagement processes with staff. It was agreed that there is an opportunity for trade unions and professional bodies to further accelerate the dialogue about the lived experience of nurses. As nurses themselves begin to talk more and reflect on the COVID-19 pandemic, it is expected that we will see much more around informal leadership, and people using social media and networking as platforms to review their lived experience. They believe that nurses will trust this commentary. There could be opportunities for trade unions to develop and deliver the messages from the nursing frontline and give voice to ambitions for different and improved ways of looking after staff.

Learning from innovation

Schwartz rounds were consistently cited and recognised as valuable strategies for dealing with the emotional labour of nursing and its impact on individual nurse wellbeing. Their adoption predates the pandemic by several years. The near universal appreciation of their value, and the continued positive trajectory of their implementation across the health community, is a reassuring reminder that progress can be made around support for nurses' mental wellbeing, if the context for adoption is properly and robustly secured.

The commentary on Schwartz rounds must also be a reminder of the importance of paying attention to the implementation of support strategies, and changes to working practice. The process of implementing Schwartz rounds is very disciplined – from getting formal CEO approval at the start, with formal procedures at each subsequent stage of implementation. The Schwartz methodology dictates what must happen in order to make change happen.

Similar observations were made by an interviewee about the Buurtzorg model of care that is being adopted in some community nursing services. The Buurtzorg commitment to hearing the voices of team members and teams, and translating these into effective and sustainable actions, were perceived as fundamental to nurses' wellbeing.

The *Courage of Compassion* report deserves recognition and adoption as the vehicle that has been most ambitious in the breadth of its vision to deliver change and learning from the work Michael West has consolidated around health leadership at The King's Fund. The document is a milestone in describing where nursing wants to be, and what we need the nursing infrastructure to do, to look like and to feel like. It describes the changes in practice the profession needs to secure, and it identified factors that must be honestly addressed. For example, that 12-hour shifts are currently the only way a vast number of women manage to earn a sufficient income whilst managing other responsibilities in their lives. It will take courage to recommend that 12-hours shifts must be eliminated if we are serious about the wellbeing of the nursing workforce. But, if nursing leaders honestly identify and raise issues, then nurses will listen, and can be actively involved in considering the solutions. Pay must be part of this discussion. The starting salary for a trained nurse is currently circa £25K and if we are honest, then we have to acknowledge that poor pay is one of the reasons nursing and employers have shaped shift patterns; squeezing in as many hours as possible on each shift worked. That honesty must extend to the calling out of specific pressures on different sections of the nursing workforce. For example, the vulnerability of nurse managers to working 60-hour weeks is different to the vulnerability of clinical nurses exposed to high levels of emotional labour in their work with patients.

The evolution of solutions like 'wobble rooms' during the pandemic were viewed by interviewees as interesting concepts designed to mitigate against potential harm to staff from their experiences of caring for patients. The appeal of these types of initiatives undoubtably lies in them being

relatively easy to deliver amongst the complexity of running a national health service during a global pandemic. It also lies in their symbolic value as a gesture from an employer that clearly recognises and acknowledges the impact and value of an employee's work. However, interviewees noted that the far more powerful question that the sector needs to ask itself is what is it that we need to do to reduce harm and how do we tackle the overflow of harm into nurses working lives? If NHS corporate values are around people feeling compassion and respect, how do we design a compassionate organisation that is felt equally by everybody as being so?

Regulatory mechanisms

There was important commentary about the role of regulatory and inspection mechanisms in trying to change staff wellbeing. There was discussion about a change in law. When we observe particular groups always being on the wrong end of a particular kind of occupational risk – as nurses have been for some time – there should be something that compels the system to change – with regulatory and inspectorate regimes policing it and commissioning processes tying this to results.

The interviews also suggested that existing HSE guidance and regulations are still not being effectively mainstreamed in the NHS as a management tool for assessing workplace mental health risks or as a legal framework for addressing employers' responsibilities. It was noted that the NHS is currently investing money in provider organisations that consistently don't deliver enough change in wellbeing for staff – despite the evidence in their own sickness absence data describing the damage being done to nurses' health and wellbeing. It is important to keep in sight that it has taken a world pandemic to elevate UK nurses work wellbeing up the agenda, not the year-on-year reporting of abysmal mental health related sickness absence data.

An analogy was drawn between the experiences of black staff and black patients. Some interviewees observed that over the COVID-19 summer of 2020 lots of senior NHS leaders were talking about Black Lives Matter and how they're committed to it, whilst their own organisations were still producing poor health outcomes for black and minority ethnic communities as patients and poor employment experiences for black and minority ethnic staff that were detrimental to their own mental health.

There was some frustration expressed that this was not being sufficiently addressed by regulatory or inspection regimes. They believed that this speaks of a failure to support leaders to be curious about how their organisations work beyond quite a narrow set of performance indicators. To do so, very different metrics, and some very different accountability measures, are needed that requires people to do something differently, and that might have to be a legal lever.

Accountability, inclusion and wellbeing

Most interviewees noted a push in the system at the moment, which they perceived as having been really useful, coming from Prerana Issar, chief people officer for the NHS. This is discussing different asks about accountability and inclusion and which could and should create different outcomes in relation to wellbeing. Observations were made about skills in creating change – and about honesty in speaking about personal experience and sharing that. Commentary from an NHS equality and diversity council meeting was cited where discussion focussed on the dynamic of asking individuals to change things in the NHS, whilst leaving systems and processes that deliver inequality and inequity intact. It was noted that it's only when you require people to do different things as a result, that change happens – so what do you need to change in your systems to create inclusion and enable inclusion to help people perform at their highest level of productivity and wellness? There was a welcome belief that the recent NHS people plan was a living document that is explicitly trying to drive and guide managers in the delivery of this.

Impact of the 2019 NHS Staff and Learners' Mental Wellbeing Commission

Ten years after Boorman, the Chair of Health Education England, Sir Keith Pearson, led an ambitious review of the ownership and leadership of staff wellbeing strategies for the NHS workforce. The work led to the adoption of the NHS Workforce Wellbeing Guardian role at board level in every NHS organisation and the alignment of their work around nine NHS workforce well-being guardian principles, supported by an NHS workplace wellbeing leader.

Given the quality and ambition of this work, it is disappointing that interviewees were unable to cite more evidence of NHS Trust boards promoting staff mental health and wellbeing at the heart of their work, or championing it at board level, as a result of Pearson's work in 2019. In the Spring/Summer of 2020 there was limited evidence of the NHS Workforce Wellbeing Guardian roles being implemented at board level in NHS organisations. Disappointingly, there was no clarity on what impact the roles were bringing to NHS board leadership and NHS Workplace Wellbeing Guardians were not yet routinely discernible in NHS organisations – 18 months after the review established the roles.

Interviewees also noted that the act of establishing guardian roles is not enough to empower them – they have to operate in a structured system that reinforces their authority. Interviewees noted that an earlier generation of guardians, the Robert Francis driven 'freedom to speak up guardians', haven't been enabled to make a sufficiently powerful impact on the speaking up arrangements that the NHS needs.

Whilst they were largely unable to cite sufficient leadership activity specific to the 2019 *Pearson Report,* there was commentary that suggested it had shaped some of the staff well-being elements of the response to COVID-19, which they found very encouraging.

There was also robust support for the principle of what the review was trying to deliver given that nursing staff are an increasingly scarce resource. Some interviewees described a system still attuned to times of plenty in terms of workforce numbers, and which is still wasteful in terms of tardiness in addressing wellbeing in the nursing workforce. They were clear that this had to change.

There was wide support for full implementation of the recommendations of Pearson's 2019 *NHS Staff and Learners' Mental Wellbeing Commission* as an example of a genuinely system wide and comprehensive process for leveraging change in the NHS approach to staff wellbeing from the top table of NHS organisations. The NHS needs to further invest in realising its full implementation and potential.

Support for the Courage of Compassion principles

All the interviewees recognised that commentary on concerns about nurses' mental health and wellbeing had reached a crescendo in 2020. This started with the RCN Foundation funded Society of Occupational Medicine review of the breadth of the literature describing the poor mental health and wellbeing of the nursing workforce. It progressed through to the RCN Foundation commissioning Suzie Bailey, the King's Fund director of leadership, to review that related literature from a leadership perspective. Her report, The *Courage of Compassion*, published in September 2020, set out an action plan to direct a series of related recommendations. These recommendations expressly focus on transforming workplaces, by developing good work environments for nurses through changing workplace factors that affect nurses' well-being and effectiveness at work, rather than relying on strategies that enable nurses to be more resilient and cope with those stressors.

All the interviewees believed that there are benefits to be derived from adopting this approach. They reflected on how placing the burden on the nurse whilst leaving systems intact was a wilful blindness on the part of organisations that had to change.

The report was published the same month as the interviews started and it was not possible to assess interviewees confidence in the adoption of the specific recommendations themselves. However, there was support and optimism around the report's key tenets of enhancing the authority, the empowerment and the influence of nurses to shape the culture and the processes of their organisation and to shape decisions on care.

Interviewees endorsed the requirement for the introduction of UK wide minimum standards of nurses working conditions and facilities across all health and social care sectors, including the independent sector. This was described by one interviewee as the professional sovereignty of nurses – a very clear set of standards around ensuring that nurses are able to work at their highest level of capacity, and to do so safely. Being explicit about tackling the chronic excessive work demands that exceed the capacity of nurses to deliver safe quality care, and reinforcing efforts to increase staff numbers, were seen as integral to this requirement. Respondents were open to more workforce engineering as seen in the introduction of nursing associates in England in recent years and they robustly supported increasing nurse training numbers. The commentary from Scotland on its success in enhancing nurse training numbers is a reminder of what can be delivered through commitment and tenacity.

Whilst improving the supply of nurses was seen as absolutely critical, so was the desire to ensure that the service does not squander the experienced nurses already in the system by the experience of routine discrimination or being made unwell or disabled through their work. Some interviewees spoke of the need for a more active confrontation of the fact that the current nursing labour market, whether it's across the NHS, or in the independent sector, is completely imperfect in the way it wastes what it currently has in terms of nursing resources. Mental health related sickness absence was seen as a crude measure of that waste by a given employer – much of it should be avoidable and there needs to be some powerful efforts to fix the current squandering of staff resources on excess sickness.

There was also some commentary about observations being made by cohorts – particularly BME cohorts considering nursing as a career – that an investment of compassion and time and money will not yield a return on investment in terms of a nursing career that has poor systems of protection against damage to wellbeing. The *Courage of Compassion* recommendation around ensuring that nursing is driven by leaders who are selected and developed to model compassionate and inclusive leadership was seen as very relevant to the delivery of these changes.

There was articulation of the need for more investment in terms of defining what we mean in nursing by compassionate and inclusive leadership and the shaping of this into a fully adopted competency framework – work that the CNOs could possibly initiate? To create momentum around using the *Courage of Compassion* report as the driver and road map, groups of provider organisations in a locality should collaborate. They could create metrics and be convicted enough to say that what we currently have does not deliver what our patients deserve and have a right to expect – and that what we currently have does not deliver the leadership that our staff deserve and have a right to expect. This then needs to be backed up with heavy investment in high quality leadership and development training for their nursing leaders locally. This could enable them to model the sense of justice and fairness in the work culture of those organisations and create the

sense of psychological safety – noted in the *Courage of Compassion* report, in which nurses can recognise the need for change and focus on learning rather than blame. As an example of this, reference was made to how a cohort of BME midwives and nurses working in maternity services had managed to gather colleagues together to enable people to be listened to and heard in terms of their COVID-19 experiences. They published their observations in a document called *Turning the Tide*, and had gone out of their way to feed this back to Jacqueline Dunkley-Bent as Chief Midwife, and Ruth May as Chief Nurse in England.

Appendix 2

Nursing and health leader interviewees

Karen Bonner	Chief Nurse	Buckinghamshire Healthcare NHS Trust
Dr Steve Boorman	Subject Expert & Author of the Boorman Review	
Yvonne Coghill	Deputy President	Royal College of Nursing
Catherine Gamble	Mental Health Adviser	Royal College of Nursing
Jocelyn Cornwell	formerly Chief Executive	Point of Care Foundation
Jennifer Gardiner	Assistant Director	NHS Employers
Sarah Gorton	Head of Health	UNISON
Helen Greatorex	Chief Executive	Kent and Medway NHS and Social Care Trust
Nigel Harrison	Pro Vice Chancellor & Dean	Anglia Ruskin University
Wendy Irwin	Equalities Adviser	Royal College of Nursing
Dame Donna Kinnair	CEO and General Secretary	Royal College of Nursing
Fiona McQueen	Chief Nursing Officer	Scotland
Claire Murdoch	Chief Executive	Central and North West London MH Trust and National Director for Mental Health, NHS England
Andrea Sutcliffe	Chief Executive	Nursing and Midwifery Council
Shahida Trayling	Deputy Chief Nurse	North Middlesex University Hospital
Paul Vaughan	Director of Nursing, Transformation	NHS England