THE CASE FOR A CHARTER FOR PSYCHOLOGICAL WELLBEING AND RESILIENCE IN THE NHS

A Discussion Paper from the Wellbeing Project Working Group
Joint Initiative between the BPS and New Savoy Conference

Dr Amra Rao, Dr Gita Bhutani, Jeremy Clarke, Neelam Dosanjh, Sanjivan Parhar
Corresponding author: Dr Amra Rao psychologicalhorizons@gmail.com
The Case for A Charter for Psychological Wellbeing and Resilience in the NHS

Executive Summary

This working paper explores the case for a charter for staff wellbeing for psychological therapy services. Staff wellbeing is recognised as a key factor in whether the NHS can deliver good quality care to its patients. ‘Physician, heal thyself’ (Luke Ch. 4, v. 23) is a real challenge in today’s NHS as many NHS staff are reporting low wellbeing. In recent years, we have been tasked with scaling up universal access to evidence-based therapy provision with the expectation that this will improve the wellbeing of the nation. Whilst a significant effort has been made to achieve this vision, there are many questions emerging. How should this translate also to the NHS’ 1.3 million workforce needs? And closer to home what impact will the ‘industrialisation of therapy’ have on wellbeing of people delivering these services? Do our leaders, managers or provider organisations undergoing this rapid transformation have their own wellbeing and that of their staff sufficiently in mind to deliver evidence-based therapies sustainably? Or have we fallen prey to chasing targets in such a way that declining wellbeing within mental health is becoming a zero-sum game?

This paper describes a joint initiative by the Leadership and Management Faculty of BPS Division of Clinical Psychology and New Savoy Conference to undertake a review of workforce wellbeing in psychological services. It reports the results of a snapshot survey of staff wellbeing in psychological therapies in 2014 and compares these with a similar survey undertaken at the start of the national programme for Improving Access for Psychological Therapies (IAPT) in 2009. The themes from the focus group consultation at the 8th New Savoy Conference in 2015 are discussed. Findings of this project are then considered to see how we can start to improve our own staff wellbeing. A case for a charter for wellbeing at the workplace is put forward as a positive step to enable practitioners to take back the wellbeing agenda.

The argument we make here is an ambitious and optimistic one. If our answer to the question above about the quality of our leadership is ‘yes’ – we believe they have the ability to scale up access without sacrificing staff wellbeing, then collectively we may have something uniquely valuable to offer the wider NHS workforce. By joining forces and using our psychological insight we can play a significant role in enhancing wellbeing in health and social care as well as in other public sector provision. The alternative scenario is more worrying. If the answer to the question about chasing managerial targets is ‘yes’ – we believe our leadership is selling our discipline short at a time when the NHS is already challenged by austerity and funding constraints. In this more worrying scenario our prediction is that the policy of improving the wellbeing of the nation itself will become unsustainable. To ensure the future is more optimistic we draw attention now to concerns about the impact of targets on the psychological services workforce and question whether the very thing we have to offer – a psychological understanding of wellbeing – is being intelligently applied within our own services. The positive step we advocate is in line with the view of Simon Stevens, Chief Executive of NHS England: first we must look to put our own house in order by showing how clinicians can step up to take back the psychological wellbeing agenda.
Part 1: Does the NHS get staff wellbeing?

The importance of wellbeing is increasingly recognised across professional, public, policy and political circles. However, concerns are emerging about some organisational cultures that compromise the delivery of care and wellbeing of their own workforce. The Francis Report (2013) highlighted failures in the way some NHS organisations failed to think about providing compassionate care. It noted serious victimization of those who were raising concerns about appalling breaches of patient safety and suffering caused, leading to a vicious circle of staff and patient welfare being systematically compromised because, ‘the NHS was putting the business of the system before the needs of patients’ (Francis Report, 2013). In a wide-ranging and thoughtful report Lord Francis made a powerful intervention – ‘the blame culture must be eradicated and compassion must be put back at the heart of everything the NHS does’. We argue that for this to happen we need a psychological understanding of wellbeing to bring about a cultural shift and that NHS psychological professions can support this.

Bullying and ill-treatment in workplaces is reported to be widespread (ACAS, 2015). Structural and aversive racism is also not uncommon in the NHS. This includes behaviour that can seem trivial such as social avoidance of an ethnic group, making assumptions about a group or constantly drawing attention to difference in order to exclude (Kline, 2014; Beishon et. al. 1995; Mistry & Latoo 2009; Staines 2006). The cumulative effect of such behaviours can be very damaging.

The proportion of staff being bullied, harassed and abused by colleagues and managers is on the rise (NHS Staff Survey, 2014). Under half of such cases are reported, the proportion falling from 54% in 2004 to 44% last year. Lack of time (32%), need to meet performance targets (23%), staff burn out & low morale (18%), and organisational culture (18%) are regarded as the biggest obstacles to delivering compassionate care (Kings Fund, NHS Culture & Leadership, 2014). In addition, just under 25% of health care workers reported feeling under excessive pressure every day with 50% unhappy with their work-life balance (CIPD, 2013). In 2013-14, NHS staff were off sick 15.7 million days (HSCIC, 2015). In mental health, 1 in 6 staff reports having suffered physical violence from patients in the previous year (NHS Staff Survey, 2013). If the day-to-day reality of your working life starts from here, then compassionate care may well look like a mountain that is impossible to climb.

The Boorman Review (2009) was able to show, however, that organizations that prioritised staff health and wellbeing perform better, with improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower rates of sickness absence. Furthermore, it became clear to the review team that the health and wellbeing of the workforce is a key indicator of organisational performance and patient outcomes. Boorman found that cultures of engagement, mutuality, compassion and respect for all - staff, patients and the public - provide the ideal environment within which to care for the health of the nation. ‘When we care for staff, they can provide outstanding professional care for patients’ (NHS Health & Well-being Improvement Framework, 2011/12).

Simon Stevens, Chief Executive of NHS England, has recently reiterated the urgency of these messages, ‘NHS staff have some of the most critical but demanding jobs in the country. When it comes to supporting the health of our own workforce, frankly the NHS needs to put its own house in order. At a time when arguably the biggest operational challenge facing hospitals is converting overspends on temporary agency staff into attractive flexible permanent posts, creating healthy and supportive workplaces is no longer a nice to have, it’s a must-do’. (02.09.15). Stevens has proposed a renewed focus on improved health and wellbeing in the NHS workplace with a framework on how NHS organisations will be supported to help their staff to stay well, including serving healthier food, promoting physical activity, reducing stress, and providing health checks covering mental health and musculoskeletal problems – the two biggest causes of sickness absence.

So – if psychological wellbeing at the workplace is a ‘must do’, what role should psychological professions be playing in this renewed drive towards improved NHS staff wellbeing?
STATE OF WELLBEING IN PSYCHOLOGICAL SERVICES

A key focus of psychological therapies is enhancement of subjective wellbeing alongside improving health outcomes. Psychological services have gone through a major structural and cultural shift in recent years. There has been a move from a cottage style industry to the national IAPT programme. One of the central planks of this programme has been its promise to target help at those who are struggling with sickness absence and inability to work due to depression and anxiety. The programme has put a sharpened focus on being accountable, through rigorous reporting on access and performance targets alongside recovery rates. Commissioning of NICE-approved therapies has ignited a debate around the methodology used for evaluation and definitions of effectiveness, and has created tension in the existing workforce. Nevertheless, IAPT has mobilised a cultural shift bringing a general acceptance amongst policy makers and healthcare organisations that access to evidence-based therapies has a pivotal role to play in improving mental wellbeing. Whilst IAPT has undoubtedly improved access for many more people than previously able to benefit from therapy free at the point of need, what is less clear is whether this is making a difference to improved mental wellbeing for the NHS’ 1.3 million staff? Stress and depression are key contributors to poor staff wellbeing with over one third of staff reporting work-related stress (NHS Staff Survey, 2013). Healthcare professionals as a professional group have amongst the highest rates of suicide for any occupational group in England and Wales (Meltzer et al., 2008). It is a cause for concern, therefore, that when it comes to implementing NICE guidance for improving mental wellbeing in the workplace less than two thirds of NHS Trusts have any plan or policy in place for supporting the mental wellbeing of their own workforce (Sloan et al., 2014). How can we build on achievements to date to shift the NHS culture?

We know rates of sickness absence are consistently higher in mental health services than the rest of the NHS, and higher in the NHS than other sectors (Quality Watch, 2015). A recent report on social care looking at care of people with dementia identified issues of staff retention and recruitment impacting negatively on quality of care (Knapp et al., 2014). In psychological therapies a review into Psychological Wellbeing Practitioners noted alarming reports from some areas that over 9 out of 10 PWP’s were leaving after only 12-months post-qualification as soon as it was possible to move to another role (high intensity CBT) [UCL-CORE, PWP Review 2012-13 Phase 1]. The review found:

- lack of career opportunities, the stress and nature of the role (in significant part related to the high volume of patients seen), and importantly the limited value for the role and lack of support in the role. [Reasons in some areas 9 out of 10 PWP’s were leaving their NHS positions only 12 months after completing their HEE-funded training].

Even more worryingly a recent press release issued by BABCP (25.09.14) warned of a “bullying culture … putting vulnerable patients at risk”, drawing attention to the increasingly coercive, managerial environment in the new psychological services. Such concerns for staff wellbeing and the need to improve support structures have also been flagged up by the Accreditation Programme for Psychological Therapies Services in their first year review (2015).

So on the one hand it is clear the NHS gets staff wellbeing and the contribution this makes to patient outcomes. On the other hand, it admits there is a gap between policy and practice (Simon Stevens). If the gap between an aspiration to reduce sickness absence in the workforce generally through access to psychological therapies and the reality of pressures on frontline staff delivering these services gets wider, then policy will become unsustainable.

[an] NHS management culture of bullying and intimidation, preventing [us] from openly raising [our] concerns and undermining our clinical judgment” (British Association for Behavioural & Cognitive Psychotherapies, 2014)
DO HEALTH PROFESSIONALS GET THE IMPORTANCE OF THEIR OWN MENTAL WELLBEING?

Between 2005 and 2013, 24 doctors committed suicide and another 4 are suspected to have committed suicide while under investigation from the GMC (Horsfall, 2014)\textsuperscript{xv}. Case reviews showed that many of them were suffering from mental health and drug or alcohol issues. Suicide rates are considerably higher and prevalence of mental illness is also higher amongst the medical profession compared with the population generally (Harvey et al. 2009)\textsuperscript{xvi}. Attitudes of shame, as well as fear about confidentiality and the negative impact on one’s career of disclosing mental illness, mean that doctors are often reluctant to seek help when they do experience problems (Chew-Graham et al. 2003; Hillis et al., 2012)\textsuperscript{xvii}. Mental health issues are the most common health issues in fitness-to-practice investigations (GMC, 2013). In a culture where there is an expectation of blame, the risk of mental health problems being conflated with unfitness to practice will almost certainly outweigh benefits of disclosing a need for help (Brooks et al., 2014)\textsuperscript{xviii}.

The stark facts about doctors and suicide, however, should not overshadow a more pervasive set of problems related to stigma and mental illness. Over recent years in conjunction with the Time to Change campaign, research has been carried out annually into experiences of stigma and discrimination amongst people with mental illness. This includes suffering prejudice from healthcare and mental health professionals most commonly in the form of not being taken seriously, but also through lower expectations of recovery amongst staff who are often themselves burnt out (Henderson et al., 2014)\textsuperscript{xviii}. Unseen or unchallenged stigma then becomes a disaster for patients and staff alike. People report feelings of shame and guilt when their illness prevents them from working (Boorman, 2009). For those with chronic or recurrent depression and anxiety, whose need for effective psychological therapies is being ignored, there is more chance if they remain off sick for more than 6 months they will die than get back to work (Waddell & Burton, 2006)\textsuperscript{xix}.

We are only just beginning to understand the institutionalization of structural stigma. There is a recognition in Parity of Esteem campaigns that what has gone on for decades is a situation where we come to expect underfunding and neglect of our mental health services. This draws a parallel to internalized stigma that exists amongst our service users – viz. ‘why try?’ (Corrigan et al., 2009)\textsuperscript{xx}. We need to have a better understanding of the causal links between endemic social and professional devaluing of mental wellbeing support and institutional factors such as poor or even harmful mental health services that are driving higher staff sickness rates.

We are not here in a position to do more than recommend further research. To date we have not systematically measured staff wellbeing. Undoubtedly, though, just as we should heed the warning signs of poor staff wellbeing for their impact on patients as well as on staff, we also need to deploy psychological insight much earlier in the causal pathway that otherwise can end at the point of suicide for some staff as well as some patients. One starting point, therefore, is the need to take seriously the issue of staff wellbeing in psychological therapy services, including routine measurement of staff wellbeing and early effective intervention for work stress.
A shift in the right direction occurred with a coming together of professional bodies and mental health charities to agree the New Savoy Declaration. The Declaration asserts entitlement to universal access to psychological therapies at the heart of mental healthcare. The *Time to Change* campaign focuses on service user needs; the Declaration makes no distinction between public and professional.

‘Psychological therapies can help people of all ages and all backgrounds to recover and stay well …’ New Savoy Declaration, 2007

Once it is recognised that subjective wellbeing is an important ‘common good’, it may be thought that the value of compassion would become more apparent at all levels of healthcare: structural, interpersonal and intra-personal. However, to ensure this, we would need to systematically reduce barriers to seeking help for depression and stress amongst professionals with the same priority we give to address stigmatising attitudes to patients. *Would measuring staff wellbeing, then, be a first step towards reducing self-stigma?*

**IMPLEMENTING IMPROVED STAFF WELLBEING: WHERE’S THE CATCH?**

For those organisations that do get it right there are significant pay-offs to them and their staff. Higher staff engagement is associated with 13% lower staff turnover as well as lower sickness absence rates (Black, 2008)\textsuperscript{xxi}. It has been estimated by a leading Consultancy firm, that for every £1 invested in staff health and wellbeing the organisation can gain £9.20 benefit (PwC, 2008)\textsuperscript{xxii}. A Department of Health review found that an NHS provider with 3,000 staff could save £235,000 costs on staff absence by matching the best 10% of NHS employers on staff engagement (DH, 2010)\textsuperscript{xxiii}.

While there is an increasing call for evidence-based staff wellbeing programmes from various professional and other bodies (e.g. Work and Wellbeing in the NHS, Royal College of Physicians RCP, 2015; The Case for Healthy Workplaces, Royal College of Nursing, RCN, 2015) there is a noticeable conundrum: ‘why is it, when we know the financial and other benefits, and we have the guidance from NICE, and we’ve had reports like Boorman’s Review for years, - that the rhetoric of good intentions does not translate into reality of improved staff wellbeing?’

‘After at least two decades of rhetoric on these issues, we are yet to see effective or consistent change … NHS organisations must take mental wellbeing seriously: stress, ‘burn-out’ and mental ill health are major causes of sickness absence in the NHS …’ (Royal College of Physicians, 2015).

There appears to be an understanding of the issues but a failure to harness this to make a difference. Recent research suggests that work has intensified and that workers are being expected to work harder, faster and to tighter performance targets (Felstead et al., 2013)\textsuperscript{xxiv}. This may explain the fact that job satisfaction is on a long-term downward trend (Green & Tsitianis, 2005)\textsuperscript{xxv}. The Francis Report (2013) identified “failure to tackle challenges to the building up of a positive culture, in nursing in particular”. Findings from the Royal College of Nursing survey of its members attributed this to NHS employers “adopting panic behaviours”. Using the Health and Safety Executive (HSE) indicators for stress at work, the RCN reported wellbeing levels amongst nurses at 2.5 compared to wellbeing levels of 3.44 in the general working population (Beyond Breaking Point, 2013)\textsuperscript{xxvi}. A major study into nursing demonstrated links between nurse wellbeing and quality of patient care and identified two key issues that mediated staff levels of wellbeing: (a) job control and autonomy (b) leadership and good relationships with colleagues (Maben et al., 2012)\textsuperscript{xxvii}.

‘The RCN would like to see the HSE take a robust approach to organisations that fail to meet the legal requirement to assess and manage the risk of work-related stress ... Stress can damage individual health and wellbeing, team relationships and ultimately affect patient care.’(Royal College of Nursing, 2013)

The RCN has made recommendations to improve wellbeing at work for nurses across 5 domains: work-life balance; dignity at work; health and safety; job design and learning and development. The aim is for providers to sign up to the RCN pledge and use a toolkit to co-produce a good working environment. The RCP, likewise, makes 10 key recommendations:

*for NHS Trusts, health boards and commissioners* prioritise staff engagement and wellbeing; implement NICE guidance on public health interventions for the workplace; champion proactive occupational health; take mental wellbeing seriously; value the role of supervisors and line managers; act on inequality; and enable staff to influence; *for government, devolved administrations and national partners* empower NHS organisations to take action; demonstrate national leadership; *for RCP* empower physicians to lead.

The Commission on Wellbeing (2014) identified four factors that determine wellbeing at work: (1) a clear idea of what is expected of you and how you relate to the wider whole (2) freedom and autonomy over how you do your work (3) recognition and reward for what you do and support so you can do it well (4) a reasonable work-life balance. Clearly, then, the NHS is not short of guidance. There remains a gap between translating good intentions into reality of improved staff wellbeing. *What is needed to bridge this gap?*
REPAIRING THE ROOF WHILE THE SUN IS (STILL) SHINING --- A CHARTER FOR STAFF WELLBEING

Simon Stevens’ announcement of £5 million for a new nationally specified occupational health service for GPs from 1st April 2016 has been welcomed by the Royal College of General Practitioners (RCGP): “GPs are working harder than ever to meet increasing patient demand with limited resources and this unrelenting workload pressure undoubtedly puts our physical and mental health at risk. Fatigue, stress – and eventually burn-out – among family doctors is increasing … Better access for GPs to occupational health services is a positive step forward” (Dr. Maureen Baker, Chair, RCGP, 2nd September 2015). In addition, 10 local NHS organisations with NHS England will spearhead a renewed drive for improved wellbeing for their staff, including “providing specific capacity for mental health talking therapies”. This represents clear recognition and opportunity for psychological therapy to help improve staff wellbeing.

The Chancellor’s announcement of a further £600 million investment into mental health must be even more welcome at a time when spending cuts are happening elsewhere. After acknowledging that mental health is “one part of our NHS that has been neglected for too long”, George Osborne has said he was building on the foundations of the previous Parliament’s move towards “equality of treatment, with the first ever waiting time standards for mental health … with £600m additional funding – meaning that by 2020 significantly more people will have access to talking therapies, perinatal mental health services, and crisis care” (Spending Review and Autumn Statement, 25th November 2015). There is a clear opportunity, therefore, over the next 5 years to develop a joined up approach to staff and patient wellbeing but, equally, there is a clear risk of increased pressures if access and waiting times targets are under-resourced or poorly implemented. If psychological professions are to play a pivotal role these welcome announcements must translate into two steps forward in tandem and not one step forward each, followed by two steps backward! So what must a joined-up approach to improving wellbeing also include?

‘By 2020 significantly more people will have access to talking therapies, perinatal mental health services, and crisis care’. (Spending Review and Autumn Statement, 25.11.2015)

Following the Francis Report (2013) a widespread consensus has emerged that for the NHS to meet rising patient demand it must renew its focus on staff wellbeing. The first step it seems to us is for clinicians to fully reclaim this agenda (Buist & Middleton, 2013)xxviii.

Amongst the clearest findings from the two National Audits of Psychological Therapy Services (NAPT, 2011; 2013)xxvii were the worrying numbers of talking therapies staff being asked to deliver therapies they were not trained to deliver and without appropriate supervision. How had this come about? Likewise, we have seen serious concerns being expressed about a bullying and highly pressured managerial culture. What are we to do about this? Whilst waiting time standards are much to be welcomed for the benefit of our patients, they will necessarily add to pressures on staff already struggling to meet targets. Clearly, there needs to be an equal balancing focus on quality.

An Accreditation Programme for Psychological Therapies (APPTS)xxiv jointly led by British Psychological Society (BPS) and the Royal College of Psychiatrists sets out governance and quality core standards which are organised according to the Care Quality Commission (2013)xxv requirements that services are safe, effective, caring, responsive to people’s needs and well-led. In order to meet the standard for being well led, a service must demonstrate that it actively promotes, monitors and focus on the wellbeing needs of its staff. Within this agenda, development of a Charter for Wellbeing will give services a tool to maintain a high staff wellbeing alongside other quality standards. As an indicator of what Simon Stevens calls ‘putting our own house in order’, it may also give us further insight to help the NHS staff wellbeing challenge.

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Is It Well Led?

- Therapists report that they are supported by the service/organisation to meet the Continuing Professional Development (CPD) requirements of their professional / regulatory body
- All supervisors have received specific training to provide supervision.
- There has been a review of the staff and skill mix of the team within the past 12 months to identify gaps in the team and develop a balanced workforce to meet local need.
- The service reviews and continually improves its efficiency in order to make best use of its resources. All therapists receive well-structured annual appraisals. Note: As a minimum, this should include the completion of forms in advance of a formal meeting and a written summary of the outcome of the meeting, which is stored by the service.
- The service actively supports therapist health and well-being, for example, monitoring staff sickness and burnout, assessing morale and taking action where needed. The Quality Standards for Psychological Therapies Services, Farquharson, Heggart and Palmer (2014)
PART 2: DEVELOPMENT OF A CHARTER FOR STAFF WELLBEING

THE JOINT INITIATIVE FOR IMPROVING PSYCHOLOGICAL WELLBEING AND RESILIENCE AT THE WORKPLACE

We have noted that despite wide-ranging efforts and guidance there is still an increase in stress at work and its negative impact on the quality of care. Is setting out of guidance good enough? It appears not. Critical engagement with this question, therefore, is vital to improve our understanding of the potential barriers to a cultural shift towards shared responsibility to enhance resilience and workforce wellbeing and ultimately its impact on the quality of care.

A working group for the joint initiative is formed from the New Savoy Partnership (NSP) & the Leadership & Management Faculty of the BPS Division of Clinical Psychology to investigate barriers to change and canvass wider views. The initial objectives of the initiative are as below:

1. Conduct an annual measure of staff wellbeing in psychological therapies
   - Use the 2009 questionnaire as a basis, refine and repeat annually from 2014
2. Canvas views and engage stakeholders in developing a charter of wellbeing for psychological therapies
   - Use a Focus Group session at the 8th New Savoy Conference
3. Develop a strategic framework for improving staff wellbeing in psychological therapies
   - Capture the learning from 1 & 2 into a Working Paper for dissemination and consult on the strategic framework
   - Consider how the learning from this work could translate into an offer from psychological therapies towards meeting the wider NHS staff wellbeing challenges

The first stage of this project was undertaken in two phases:

- Phase 1 to conduct a Wellbeing Survey
- Phase 2 to report results of the Survey and engage a Focus group discussion on a charter for wellbeing.

1. Wellbeing Survey: An online survey was undertaken during Dec 2014-Jan 2015 (see Appendix 2). The Staff Wellbeing questionnaire was sent to members belonging to a range of professional networks. The questionnaire comprised of 26 closed questions from three key wellbeing domains, and an open section for respondents to provide any comments they wished to raise. The methodology followed the previous New Savoy staff wellbeing survey undertaken in 2009 at the beginning of the national IAPT program, which had reported on levels of wellbeing at the 3rd New Savoy Conference (November, 2009). The questionnaire was developed based on consultation with a range of experts in measuring wellbeing as well as with psychological therapy clinicians and organizations within the New Savoy Partnership. It was agreed to use the New Economics Foundation (NEF) wellbeing questionnaire as the main basis for our questionnaire to provide some comparison with general population wellbeing. Some further questions were added to the 2014 version to cover additional specific issues that stakeholders felt were impacting on staff wellbeing since 2009, and modifications to the response sets. Respondents were also asked to provide additional demographic details, along with their role, position and organization so that interpretation of the results ongoing could be related, for example, to the demands and pressures in different working contexts. The three broad domains of wellbeing used in the questionnaire are outlined below, with sub-domains.
Summary of Respondents to the 2014 Survey:

851 people responded. 72.5% of participants were White British; 35.1% of the ethnic minority respondents were Indian and 45% were Afro-Caribbean. The majority age range was 41-50, with 28.1% of participants choosing this category; 4.6% of respondents were over the age of 61. The majority of respondents were female (77.9%). The most popular salary bracket was NHS Agenda for Change Band 7 (31.3%)

II: Focus Groups: The findings of the survey were presented at the NSP conference (2015) on day 1. Conference delegates were also invited to participate in the focus group discussion on day 2.

The aims for the Focus Groups were to:

a) Explore the findings of the survey
b) Scope options for the development of a Wellbeing Charter
c) Consider how this could be used and monitored to enhance staff wellbeing.

Three separate Focus Groups were formed to explore implications of the Joint Initiative for:

a) Individual clinicians
b) Psychological services
c) Professional bodies and policy makers.

Questions posed to each of the group are outlined in the boxes below.
FINDINGS OF THE SURVEY

Responses to questions and comments were analysed across the three domains of well-being to extrapolate trends. Findings are presented below.

**Personal Wellbeing:** Just over 50% of respondents said they were often enjoying life but just over 40% also reported feelings of depression some of the time, often or all the time. Health was reported to be generally good but again problems with sleeping were indicated by two thirds of respondents. Perhaps more worrying 42.4% of respondents reported feelings of failure some of the time, often or all of the time. If we were confident robust systems of reflective practice were in place this would be less worrying. Are we?

**Social Wellbeing:** Most respondents indicated having enjoyable lives with their families and that they had people with whom they can discuss personal matters. They also reported that they felt respected by others. These findings are more reassuring.

**Wellbeing at Work:** Warning signals were clearest from the finding that just under 95% of respondents found their jobs stressful some of the time, often or all of the time. Likewise, two thirds felt pressurised into working long hours, three quarters beyond what they were paid for, and just under 90% pressured into meeting targets. One in six staff reported incidents of bullying and harassment and almost one in three had observed others being subjected to it. A clear majority (60%) felt time spent on administration and reporting performance was excessive and a substantial minority (30%) that too little was spent on clinical supervision / CPD.

**Comments from the respondents:** 252 participants made comments out of a total sample of 851 giving a comment rate of 29.6%. Identification of themes was undertaken by visual inspection of the frequencies of words or related words in the text. For example, Targets, Target-culture, Target-driven, KPIs were all grouped together as ‘Emphasis on Targets’. This led to 11 themes in which concerns were expressed as well as positive comments, grouped as one theme. The biggest group of concerns with the largest number of comments was the current ‘target culture’ (32.1%). A frequent concern about supervision and CPD suggests that respondents to the survey felt that the balance around quality and safety of care in their services, alongside meeting targets, was not being achieved.

<table>
<thead>
<tr>
<th>Theme</th>
<th>N</th>
<th>% Proportion of total participants who commented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targets</td>
<td>81</td>
<td>32.1</td>
</tr>
<tr>
<td>Availability of adequate supervision and CPD</td>
<td>38</td>
<td>15.1</td>
</tr>
<tr>
<td>Not feeling valued including structural issues such as pay</td>
<td>33</td>
<td>13.1</td>
</tr>
<tr>
<td>Stress</td>
<td>31</td>
<td>12.3</td>
</tr>
<tr>
<td>Bullying and Harassment experiences</td>
<td>27</td>
<td>10.7</td>
</tr>
<tr>
<td>Impact on quality of service provided</td>
<td>25</td>
<td>9.9</td>
</tr>
<tr>
<td>Burnout</td>
<td>22</td>
<td>8.7</td>
</tr>
<tr>
<td>Time to reflect/prepare/formulate clinical work</td>
<td>21</td>
<td>8.3</td>
</tr>
<tr>
<td>Morale</td>
<td>21</td>
<td>8.3</td>
</tr>
<tr>
<td>Increasing time spent on administration</td>
<td>15</td>
<td>6.0</td>
</tr>
<tr>
<td>Blame culture</td>
<td>10</td>
<td>4.0</td>
</tr>
<tr>
<td>Positive comments about work</td>
<td>22</td>
<td>8.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>346</td>
<td></td>
</tr>
</tbody>
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FOCUS GROUPS

Themes are summarised in the table below. The basic needs of users and staff were emphasised (e.g. physical environment of therapy rooms, secure private and confidential spaces). It was felt that professional bodies should be more vocal in influencing policy and a shift in management culture, and that clinical leaders should be more involved in commissioning. The pressures affecting services and lack of job security (e.g. three year commissioning contracts; funding constraints; organisational ‘churn’) were linked with rising staff sickness, which has doubled to 9% in 6 years since the Boorman report. It was noted that CQC has started observing mental health services but that whilst this can be a lever for change it can also create a ‘workplace face transplant’, distant from day to day reality.

<table>
<thead>
<tr>
<th>Key Principles &amp; Features</th>
<th>Key Interventions</th>
<th>Indicators of Impact</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical &amp; mental health</td>
<td>Building trust</td>
<td>Transparency &amp; honesty</td>
<td>Identify own wellbeing needs</td>
</tr>
<tr>
<td>Attention to environment</td>
<td>Organisational approach / plan</td>
<td>Management process: seen to be learning and advocating from what works well</td>
<td></td>
</tr>
<tr>
<td>Acknowledgement of different levels of needs</td>
<td>Facilitative management culture</td>
<td>Clarity of roles and tasks</td>
<td></td>
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<tr>
<td>Culture of feeling valued</td>
<td>Opportunities to develop</td>
<td>Job security</td>
<td></td>
</tr>
<tr>
<td>Managing and balancing external pressures</td>
<td>Supervision</td>
<td>Ensure own supervision needs are met</td>
<td></td>
</tr>
</tbody>
</table>

| **Organisation**          |                   |                      |         |
| Communication & participation | Variety of work, not just the caseload balance | Evidence base | Offering choice in wellbeing interventions as part of a Wellbeing plan |
| Recognise it is difficult work | Choice | Consider examples of good practice such as Cary Cooper work on caring for the carer |
| Be real about impact       | General vs. Psychological services specific e.g., job plans | Respecting the reflective space |
| Stress is not a weakness   | We are people and professionals, things do happen to us | Permission & encouragement at organisational level |
| Offering choice in wellbeing interventions | Stigma of mental health / distress | Staff should have rights under NHS constitution |
| Mindfulness is important   |   | Staff experiences: permission to take lunch break, support colleagues |
| Recognise distress         |   | Going an extra mile, Prevention |
| Spaces to chat with colleagues |   |
| Are we different or not?  |   |
| What about doctors, nurses and other mental health professionals? |   |

| **Professions / Government bodies** |                   |                      |         |
| Listen | End targets but collect data for clinical quality improvement | Human informed attitude to workforce |
| Services to have capital funding | Reduce regulation | Monitor what has happened to staff morale |
| National review | Set standards for supervision hours | Staff sickness rates |
| Monitor what has happened to staff morale |   | Clinical quality improvement |
| Join up approach |   |           |
| Stop fusing organisations, reduce regulations |   |         |

Discussion of our findings

Findings of our survey are mixed. The majority of the respondents indicated satisfaction with their jobs and said they were enjoying life with good health and social wellbeing. However, 40.4% of the respondents reported feelings of depression and 42.4% reported feelings of failure. Incidents of bullying and harassment were highlighted. And despite feeling satisfied with their jobs, worrying numbers were finding their jobs stressful, and reported having to work long hours experiencing pressure in target driven work cultures. There were also concerns about too little time spent on clinical supervision & professional development in contrast to excessive time and resources being spent in pursuit of performance targets. These are concerning findings that need to be taken seriously to explore further what is leading to these reports. These findings also mirrored comments in the focus groups.

Over 40% of psychological therapists feel depressed

(BPS & New Savoy Conference Wellbeing Survey 2014/15)
The theme that emerges most clearly is that psychological therapists feel the **quality** of their work is not being fully supported. Their concerns span from basic issues to do with appropriate physical spaces and clinical supervision/CPD to more structural issues such as attention to a range of clinical evidence, as well as clinical experience in setting standards; organisational changes being imposed without concerted efforts to engage clinicians and users in service development and improvement; and the absence of clinically informed commissioning and performance monitoring. There were suggestions for how management of psychological services could be improved through provision of facilitative and reflective spaces; setting up of forums to enable influencing of management decisions; greater clinical autonomy, responsibility and distributed leadership; open and transparent communication; and peer support and self care. There was also frustration expressed at ticking boxes where this was at the expense – and not in aid - of a coherent focus on improving clinical practice. Some participants in the focus groups expressed their doubts about the effectiveness of yet another wellbeing chart if this was just another PR exercise without being genuinely linked to a meaningful framework for staff wellbeing. We have seen elsewhere the observation that rhetoric and guidance is not enough if it doesn’t lead to actual results.

Some of our findings would appear to be related to the idea of self-stigma or self-devaluation of our worth as a professional discipline.

We are not able to say very much about the comparative significance of the results of our staff wellbeing survey at this point. It is worth noting that reported levels of depression amongst respondents were not dissimilar in 2009 to 2014. We do not know whether this should be taken to indicate that underlying systemic causes of poor wellbeing amongst psychological therapists are entrenched, or whether there is an underlying robustness and resilience to our profession in achieving such a rapid scaling up notwithstanding this. Likewise, we cannot yet compare our results with levels of wellbeing amongst other staff groups in the NHS. At present we are conducting the survey for 2015. We hope that our analysis in this iteration will begin to enable us to make some of these comparisons.

What is clear is that we have a long way to go in terms of ensuring consistently high levels of staff wellbeing that would make us more confident that we can sustain the current efforts to improve national wellbeing. Some serious thinking, reflective discussions and effective actions that are supported across organisations are now needed.
Recommendations

This paper is primarily aimed – as the title says – at generating a critical discussion. There are already in existence a number of recommendations and staff wellbeing guidance. We need to have a better understanding of the issues we have highlighted here that are specific to mental health, as well as how to ensure there is a psychological understanding of mental wellbeing within generic guidance. We have noted the fact, that there is a gap between good intentions, rhetoric, and concrete measures that improve staff wellbeing. Whilst we welcome Simon Stevens moving this agenda forwards, it is clear we need to address the root causes of poor staff wellbeing not just the symptoms. **What our initiative is aiming to do in this first phase is to try to understand more about the causes of poor staff wellbeing and develop a strategic framework in which psychological wellbeing will have a more central place in organisational plans.**

The 2015/16 wellbeing survey will be reported at the 9th New Savoy Conference. We will be launching a staff wellbeing charter, the arguments for which we have developed in this paper. The primary purpose of our Charter will be to encourage organisations to sign up and in doing so to commit to three simple actions in support of staff wellbeing that, in effect, constitute our recommendations.

1. Conduct two measure of staff wellbeing during 2016/2017

2. Consult and carry out one key action to improve staff wellbeing in-between the two measurements above

3. Nominate a senior level psychological therapist as a champion for staff wellbeing who is (a) able to talk and inspire others about overcoming their own wellbeing challenges and (b) able to represent the organisation in the BPS / NSP Charter Network and report back and share their organisation’s learning from Actions 1 and 2 above

Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – accounting for around £1 in every £40 of the total budget. This figure does not include the cost of agency staff to fill in gaps, the cost of treatment and many senior professionals, including doctors taking early retirement. The main argument for organisations signing up to our psychological wellbeing charter, therefore, are consequences of doing nothing to reduce toxic stress in the workplace: harm to patients; harm to staff; loss of staff commitment and belief in the core purpose of healthcare organisations; and loss of compassion. Just as effective therapy saves money – effective staff wellbeing saves money and places the focus back on values of compassion and care essential for human flourishing.

For those organisations who sign up there is a practical commitment towards improving staff wellbeing, and joining a network that is learning more about how to achieve a culture of mutuality, responsibility, accountability and collaborative effort towards improved safety, care and compassion at the workplace.

We have drawn attention in this paper to an imbalance towards managerial targets in psychological services, and argued that our starting point should be to address this by re-focusing on quality and starting to use an indicator of staff wellbeing to help us see how:

‘Creating healthy and supportive [psychological therapy] workplaces is no longer a nice to have, it is must do’
Part 3: CONCLUSION – REASONS TO BE CHEERFUL

If any single sector can help the NHS respond to the grim lessons of the Francis Report (2013), it is the applied psychology and therapy sector. Helping public service systems towards improved wellbeing and resilience and preventing a breakdown OR supporting a failing system that functions in crisis mode, where relationships between leaders, managers, staff and colleagues are unhealthy and toxic, must be part of our offer to the system (i.e; the former) in addition to our day-to-day work with individual patients who have mental health difficulties.

There will be significant challenges to achieving the win-win of improved staff wellbeing and effective public sector services that improve public mental health at a time of austerity when funding constraints will tighten further. The OECD report on mental health and work (2014) showed the UK has the highest inflow of new disability welfare claims, amongst whom people with depression are the single biggest group, across the OECD. In other words, as fast as IAPT and other welfare support services are helping people with depression back to work there are others, faster and more numerous, who are becoming unemployed due to their depression. They encounter a welfare system that is undergoing significant reform in which sanctions are causing even greater levels of distress.

The current system drivers such as the Workplace Well-being Charter and recent NICE guidance provide frameworks to deliver improved staff health and wellbeing in theory, including accreditation standards that organisations can be measured against. However, these do not appear to be embraced across the health sector with few having signed up to the Workplace Well-being charter. Furthermore, organisations are evidently not convinced that the clear links between investment in actions and the return on investment through improved staff health and well-being will be realised within the kind of timescale that makes a difference to their need, often, for short-term savings. There are also clearly serious barriers that are getting in the way of health professionals themselves asking for help with mental health problems – plus a routine pattern where they are putting the wellbeing of their patients before their own wellbeing needs. And if as a sector we wish to champion ways of thinking, acting and relating that will bring about services that are resilient, collaborative and effective then we will need to embody these values ourselves firstly. Nevertheless, we believe there are reasons to be optimistic - and even cheerful - that we can step up to this challenge and make a learning network that facilitates this.

Those psychological leaders who emerge also as effective system leaders over the next few years will have an ability to be able to engage leaders, and frontline staff; they will be problem solving to co-creating the knowledge, transforming lives and work – life balance that allows for flourishing networks of relationships. There is a huge need for new voices and new leadership alongside shared responsibility between leaders and staff in our public services as we enter a further period of austerity. We would encourage psychological therapists and other applied psychology professionals to engage with this agenda and ensure their own organisations start to take seriously the psychological wellbeing of their own staff in the same way that we each chose to put wellbeing at the heart of our vocation.

We look forward to meeting many of you in the BPS/NSP Wellbeing Charter Network.
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Authors

Dr. Amra Rao, Consultant Clinical Psychologist and Organisational Consultant
Amra has worked in the NHS for 24 years specialising in working with adolescents, adults, couples and families. She is Head of Complex Care Psychological Therapies Services, East London NHS Foundation Trust. She is a supervisor and trainer for DIT (Dynamic Interpersonal Therapy) and MBT (Mentalisation Based Therapy). As an Organisational Consultant and Coach she has been involved in delivering leadership, change management and team development programmes both in the UK and internationally. She has published widely in the area of leadership, compassion, consulting to teams and effectiveness of psychological therapies.

Dr. Gita Bhutani, Clinical Psychologist and Professional Lead for Psychological Services
Gita has specialised in working with older people and working age adults in her NHS work and also working with trauma and stress. Her current role is Associate Director for Psychological Professions at Lancashire Care NHS Foundation Trust, where she also works clinically within the Lancashire Traumatic Stress Service. Gita is Chair of the Psychological Professions Network-North West (www.nwppn.nhs.uk). Her current clinical and research interests are in post-traumatic stress and health and wellbeing approaches for staff. She has developed and delivers a staff wellbeing training package focused on CBT and positive imagery: Looking After Me Looking After You (LAMLAY).

Jeremy Clarke CBE, Counsellor and Psychoanalytic Psychotherapist, former National Professional Adviser, Improving Access to Psychological Therapies (IAPT)
Jeremy has worked in a number of different settings mainly in the 3rd Sector and in primary care for 25 years. He currently works in Newham offering Dynamic Interpersonal Therapy at Step 3 and also for complex care. In his previous role as National Professional Adviser for IAPT he oversaw the development of the new training curriculums for DIT (Dynamic Interpersonal Therapy), BCT (Behavioural Couples Therapy) and Cfd (Counselling for Depression). He was also National Clinical Lead for the 2nd National Audit. His interest has been in enabling informed choice of evidence-based therapies and he continues to be involved at a national level in the current DWP/DH work towards improving access for people on long-term welfare benefits. He was an expert member of the 2009 NICE Depression guideline group and is a member of the current guideline development group that is due to update the NICE Depression guidance again in 2017.

Neelam Dosanjh, Consultant Clinical Psychologist and Organisational Coach
Neelam was formerly Head of Newham Primary Psychological Services. She currently works for the Tavistock and Portman NHS Foundation Trust as an Associate of the Psychological Therapies Development Unit, and also has a private practice. She is a supervisor and trainer for DIT and IPT (Interpersonal Therapy) and is also trained in MBT. She is a member of DCP’s Leadership and Management Faculty.

Sanjivan Parhar, Assistant Psychologist and Therapy Associate
Sanjivan is a recent graduate in Psychology and Law. He is currently working with Newham Primary Psychological Services as an Assistant Psychologist and at the Priory Group as a Therapy Associate.