

Psychological Wellbeing and Resilience

RESETTING THE BALANCE

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‘NHS Staff Wellbeing Is No Longer A Nice To Have ...’

The importance of wellbeing and compassionate work places is widely recognised. Concerns about organisational cultures that compromise the wellbeing of their workforce have reached a critical point. The Francis Report (2013) highlighted a systemic failure to provide basic, compassionate care in the NHS. It noted serious victimisation of some of the individuals who raised concerns about breaches of patient safety, leading to a vicious circle of staff and patient welfare being systematically compromised where, ‘the NHS was putting the business of the system before the needs of patients’ (Francis Report, 2013). The report recommended that ‘the blame culture must be eradicated and compassion must be put back at the heart of everything the NHS does’.

Whilst Sir Robert Francis could not have been clearer, the pressures the NHS is faced with, including financial cuts, increased public expectations and more intensive scrutiny, are unlikely to lead to a return to a compassionate organisational culture any time soon. There is also a risk that the ‘political’ drivers may make matters worse. Bullying and ill-treatment in NHS organisations are felt to be widespread (ACAS, 2015). Structural and aversive racism is also not uncommon, including behaviours that might seem trivial, such as social avoidance of an ethnic group, assumptions about a group, or constantly drawing attention to difference in order to exclude (Kline, 2014; Beishon, Virdee and Hagell, 1995; Mistry & Latoo 2009; Staines 2006). As work demands have intensified, and workers are expected to work to tighter performance targets (Felstead, Gallie, Green, Inanc, 2013), many NHS staff feel that stressful work experiences are also, as a consequence, on the increase (NHS Staff Survey, 2015) (Fig: 1). The cumulative effects of such stresses are damaging both for individuals and NHS organisations. 15.7 million days were lost due to sickness in 2013-14 (HSCIC, 2015), with higher sickness absence rates in mental health services than in the rest of the NHS, and higher sickness absence rates in the NHS than other sectors (Quality Watch, 2015). It is for these reasons that: “NHS staff wellbeing is no longer a nice to have, it’s a must do” (Stevens, 02.09.15).

Figure 1: NHS Staff Survey 2015



The NHS continues to attract people who want to work in a caring profession rather than in industries that are driven, for example, by financial incentives and rewards. The conditions under which NHS staff are increasingly expected to work, however, are making them uncaring both towards their patients and towards each other. This creates a paradoxical situation. Whilst mental health professionals should be uniquely placed to contribute towards compassionate workplaces through their understanding of how

wellbeing can improve the quality of life of NHS patients, there are worrying indicators of a shift in the opposite direction here. This paper reports results of a staff wellbeing survey for NHS psychological practitioners. It considers the implications for the NHS if the psychological wellbeing of a key workforce sector is being damaged, as our survey suggests, and it proposes a strategic response for resetting the balance.

Critical State of wellbeing in medical and psychological workforces

A key focus of psychological therapies is the enhancement of subjective wellbeing and, through this central mechanism, improving health outcomes. In recent years, psychological services have gone through a major structural and cultural shift from a cottage-style industry to the national Improving Access to Psychological Therapies (IAPT) programme. One of the main policy planks of IAPT has been to target help towards those who are struggling with sickness absence and inability to work due to chronic depression and anxiety. IAPT has also put a sharpened focus on services being accountable, through rigorous reporting on access and performance targets. IAPT's high profile and demonstrable success has led to a general acceptance amongst policy makers and healthcare organisations that access to evidence-based therapies has a pivotal role to play in improving wellbeing. In theory, therefore, extending IAPT-style services to meet the needs of NHS staff could make a difference to improving their wellbeing and reducing work related stress. This is clearly important to policy makers, alongside the public policy goal of helping people to return to work. Indeed, understanding how work itself interacts with health outcomes, including wellbeing and resilience, must be central to successful implementation of mental health as well as welfare policies. It is precisely here, however, at the interface of work interacting with wellbeing, where unanswered questions remain.

Duty of care for NHS employers

Healthcare professionals have amongst the highest rates of suicide for any occupational group in England and Wales (Meltzer, Griffiths, Brock, 2008). Between 2005 and 2013, more than 23 doctors committed suicide (Horsfall, 2014). Attitudes of shame, fears about confidentiality and the negative impact of disclosing mental illness on one's career, all mean that doctors are often reluctant to seek help (Chew-Graham, Rogers, & Yassin, 2003; Hillis, Morrison, Alberici, Reinholz, Shun and Jenkins, 2012, Brooks, Busso, Chalder, Harvey, Hatch, Hotopf, et al, 2014). The impact of stigma, in a culture where there is an expectation of blame and a risk of mental health problems being conflated with unfitness to practice, outweighs benefits of disclosing a need for help. The General Medical Council has appointed Professor Louis Appleby to look into making their investigation process more compassionate: *"Two principles have guided my approach to this work. First, doctors who are ill need to be treated, not punished - investigation is frequently punitive in effect, even if that is not the intention. Secondly, suicide is not confined to those who are known to be mentally ill - it can be those who are thought to be coping that are most at risk - so reducing risk is a task for the system as a whole (Appleby, 2016)."* Professor Appleby's call for employers to take more responsibility is highly welcome, and something we look to support through our Charter below. But, worryingly, less than two thirds of NHS Trusts have any plan or policy in place to support staff wellbeing or to implement NICE guidance for improving wellbeing in the workplace (Sloan, Jones, Evans, 2014). Nor is it clear, whether those who have a plan will address how the current culture is failing dedicated professionals, as well as their patients.

People report feelings of shame and guilt if their illness means they become unable to function at work, (Boorman Review, 2009)

Why is the evidence about the impact of wellbeing at work on 'the bottom line' being ignored?

High levels of stress at work erode compassion and engagement affecting quality of care, patient experience and outcomes (West, 2014). The associated

'When we care for staff, they can provide outstanding professional care for patients' (NHS Health & Well-being)

human costs are also well known. For those with chronic or recurrent depression and anxiety, it has even been suggested that if they remain off sick for more than 6 months, there is more chance that they will die than get back to work (Waddell & Burton, 2006). The Boorman Review (2009) showed that organisations that prioritised staff health and wellbeing tend to perform better. Higher staff engagement has been associated with 13% lower staff turnover as well as with lower sickness absence rates (Black, 2008). It has been estimated that for every £1 invested in staff health and wellbeing the organisation can gain £9.20 benefit (PwC, 2008). 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). However, despite this evidence, and a plethora of national guidance, there are gaps between translating good intentions into a reality of improved staff wellbeing in our NHS organisations.

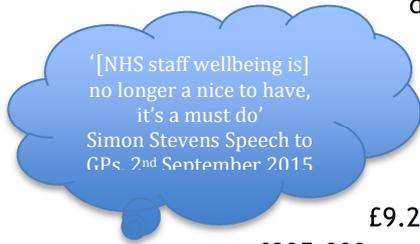
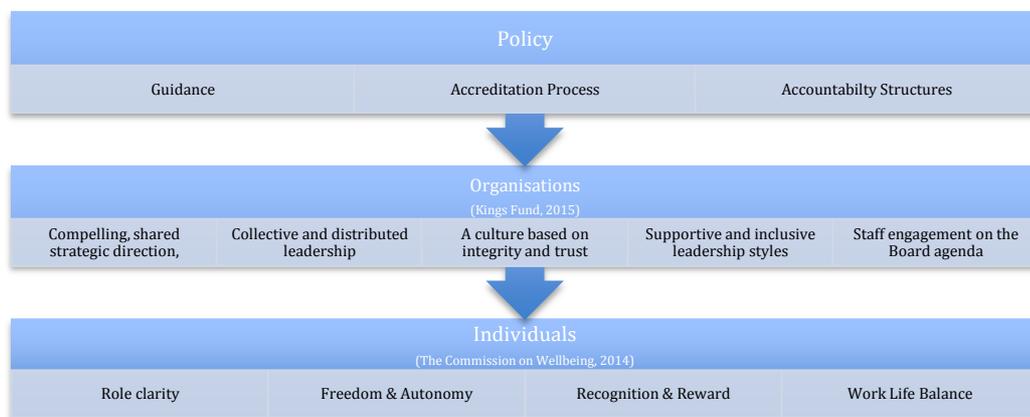


Figure 2: Factors associated with workplace wellbeing - but gaps in the systems to make it happen



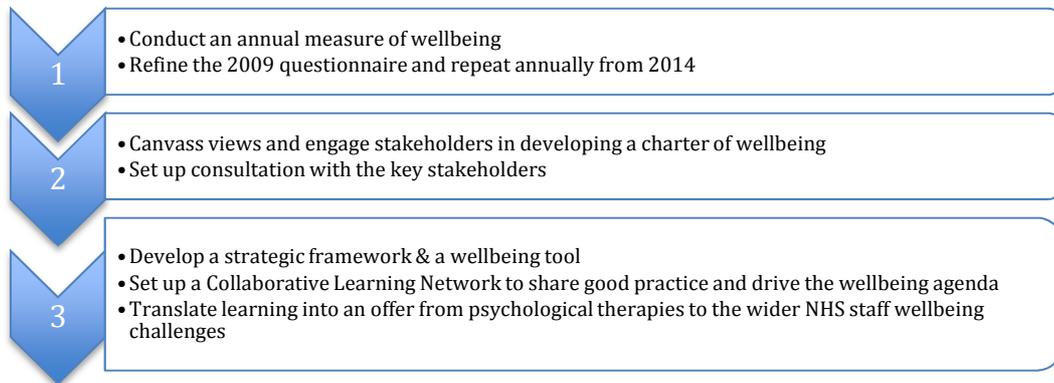
The Independent Mental Health Taskforce (February 2016) has recommended that NHS England should introduce a CQUIN (Commissioning for Quality and Innovation) or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017. It asks for NHS England to ensure that current health and wellbeing support to NHS organizations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards. National CQUIN guidance for 2016-17 includes 'introducing mental health initiatives for staff'. These welcome recommendations represent a clear recognition of the value of NHS staff wellbeing. The opportunity now exists for the psychological professions to develop a clinician-led strategy that is both collaborative and inclusive.

In the professional sector that has an obvious role to support improved staff wellbeing amongst healthcare professionals, the psychological sector, there are emerging concerns about staff retention (IAPT, BPS, December 2012), reports of bullying and oppressive managerial practices (Press release, BABCP, 25.09.14), and increased self-reported levels of stress and depressed mood (Wellbeing Survey, 2014). At present there is no systematic strategy to monitor stress and wellbeing in psychological services. The results that we report below, therefore, are our best available evidence for the current state of wellbeing amongst psychological staff. This is important to track because if the workforce tasked with delivering improved public wellbeing is unable to sustain this effort, they will be unable also to make an impact on improving NHS staff wellbeing.

The Initiative

A joint initiative between The New Savoy Partnership (NSP) and the Leadership and Management Faculty of the BPS Division of Clinical Psychology was set up in 2014 to investigate workforce wellbeing in psychological services. The objectives were set to be rolled out in three stages:

Figure 3: Objectives of the joint initiative



Based on what we had already found in our 2014 survey, and through consultation with stakeholders, we set out a case for a charter for workforce resilience and wellbeing (Rao, Bhutani, Clarke, Dosanjh, Parhar, Easton and Van Laar, February, 2016). We have drawn on learning from the first wave of services entering the Accreditation Programme for Psychological Therapies (APPTS) and evidence reviews by the Kings Fund and Commission on Wellbeing (see Fig 2 above).

In 2016, based on feedback from consultation, it was decided to launch a Charter for Staff Wellbeing with support from the BPS and a range of other leading organisations, including Public Health England and Public Health Wales, CQC, Greater Manchester devolved NHS and Combined Authorities, leading mental health Trusts and providers, leading mental health charities, professional and organisational expert bodies.

2015 Wellbeing Survey

An online survey was circulated using convenience sampling with the questionnaire being sent to members belonging to a range of professional networks. Convenience sampling supported data collection over a short period of time and did not require intensive resources for data collection. Disadvantages of convenience sampling include selection bias and the generalisability of the results cannot be assumed.

The questionnaire comprised of 33 closed questions covering three Wellbeing Domains: Personal, Social and Work. Additional questions on discrimination and quality of organisational life such as Job-Career Satisfaction, Control at Work and Employee Engagement were included from the Work-Related Quality of Life scale (WRQOL) (Easton & Van Laar, 2012, 2013). Respondents were also asked to provide additional demographic details, along with their role, position, work setting, whether they had a long-term condition or disability. There was also a section to provide comments as free text.

1348 people responded to the survey in a 4-week period. Due to duplicate responses in the dataset due to technical difficulties with the online survey, initial data cleansing reduced the quantitative dataset from 1348 to 1106. Frequency data were obtained for all the quantitative data based on this sample size. Following this, comparisons between the 2014 and 2015 survey were made on age and gender. Three key questions were chosen for comparison between 2014 and 2015 based on the frequency data. Subgroup

analyses were also undertaken for these three questions on the 2015 sample. The subgroups were Work Location (IAPT, secondary or tertiary care) and Pay Band. These were:

- How much of the time in the past week have you felt depressed?
- At times I feel as if I am a failure
- How much of the time do you find your job stressful?

In addition, the WRQOL responses from the participants were compared against normative data sets of NHS and university samples.

Demographics: 88% of respondents worked for the NHS. 54% of these worked in IAPT/Primary care. Band 7 was the main pay banding. There was no statistically significant difference in age or gender between the participants from the 2014 or 2015 survey.

Table 1: 2015 Survey demographics

Age	Percentage
21 to 30	13.2
31 to 40	27.4
41 to 50	27.2
51 to 65	30.2
66+	1.5
Prefer not to say	0.5
Gender	Percentage
Male	19.3
Female	80.0
Transgender	0.4
Prefer not to say	0.4
Ethnicity	Percentage
White	81.3
Asian	4.9
Black	2.3
Mixed	2.5
Chinese	1.0
Other Ethnic Group	5.3
Prefer not to say	2.6

Personal Wellbeing: An increase was found in reported depression and also self-reported feelings of failure in the 2015 survey results compared with 2014 results. Self-reported Depression went up from 40% in 2014 to 46% in 2015. Self-reported Feeling like a Failure rose from 42% in 2014 to 49.6% in 2015. These are the cumulative percentages across response sets of *Some of the time*, *All the time* and *Often* but these increases were not statistically significant changes from the 2014 survey results (See Figures 4 and 5 below).

Figure 4: Self-reported depression 2014 and 2015

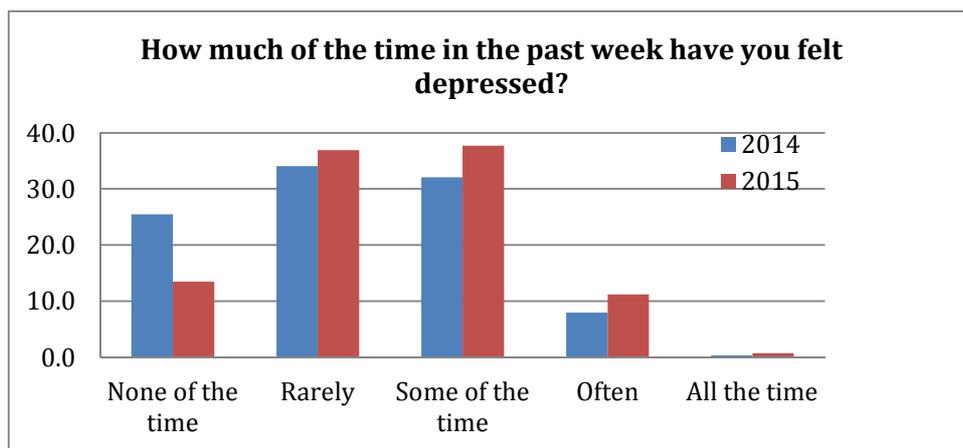
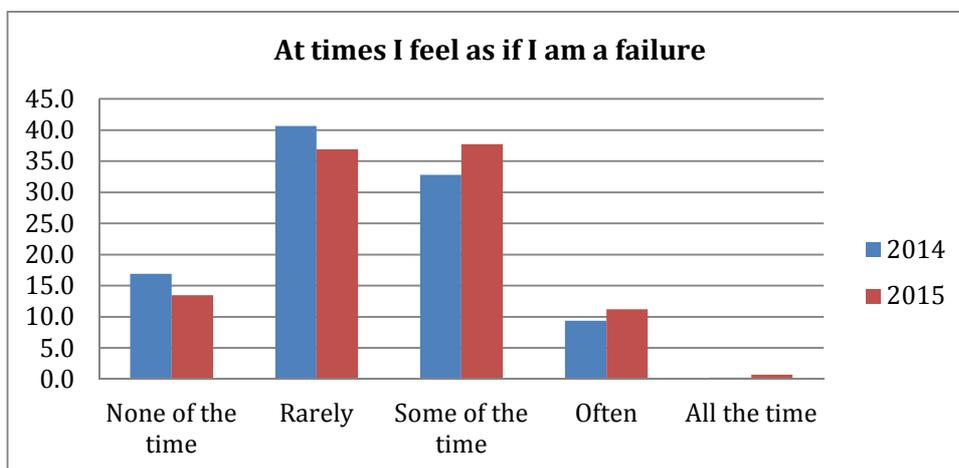
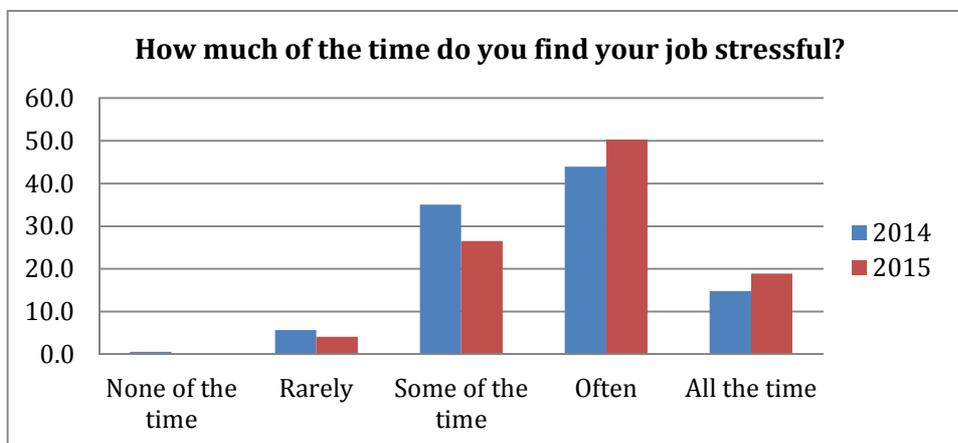


Figure 5: Self-reported feeling like a failure



Work Wellbeing: A statistically significant increase was found in self-reported experience of stress with the combined 'often' and 'all the time' categories increasing from 58% in 2014 to 70% in 2015 ($t=4.64$, $df=1957$, $P<0.001$). Figure 6 shows the changes from 2014 to 2015.

Figure 6: Self-reported experience of stress from 2014 & 2015



The banding of posts and work areas (IAPT/Primary care, Secondary care and Tertiary) made no significant differences to reporting levels of depression, feeling like failure and work stress.

Work-Related Quality of Life scale: WRQoL subscales provide benchmark scores to compare the survey sample against norms established with other relevant occupational groups, including the NHS (Easton, and Van Laar, 2012). 1106 responses were available for the survey analysis.

- Only 50% of respondents agreed or strongly agreed they had a good Job-Career Satisfaction, which was lower than that of the averages for both general NHS (60%) staff and general University staff (56%) norm groups.
- Only 42% of survey respondents agreed they had good control at work Control at Work score, again substantially lower than the general NHS (57%) and university samples (54%).
- Employee Engagement (EEN) was generally low, with only 25% of respondents agreeing that their organisation communicated well with employees, 64% feeling they did not have sufficient opportunities to question their manager.
- Overall Quality of working life. Just over 55% of respondents agreed or strongly agreed they had a good quality of working life, substantially lower than the NHS (64%) or general university (60%) benchmark groups.

Qualitative data: The qualitative data sample included the whole sample of 1348 as there were no technical difficulties with this part of the dataset. The qualitative data was analysed in terms of numbers of comments, words per comment and number of participants providing comments compared to the 2014 sample. Compared to 2014, the comment rate of 48.8% was over 1.5 times greater than the 2014 survey. There were 107 words per person on average in 2015 against 49 words per person on average in 2014. A notable increase in both the amount and breadth of comments was evident. This was not analysed statistically.

- The most common themes were ‘Targets’ and ‘Stress and Burnout’ with an increase from 32% to 41% and 21% to 38% respectively.
- An increase in comments on ‘workload’ and ‘unpaid hours of work’ (8.3 to 16.0%) was noted.
- New emerging themes were ‘an increase in the complexity of the cases’ and ‘a lack of time or option to provide a therapeutic treatment dose’. This has also been highlighted by the BABCP in 2014.
- Participants highlighted the cuts in posts and the impact of down-banding as well as reduced career progression.

Overall, the predominant picture presented was one of an increasingly negative work experience for psychological staff, with a consequent negative impact on their wellbeing and resilience. The services were often described as increasingly squeezed, and many respondents said they felt unable to offer good quality services. The work provided was increasingly viewed as ‘mechanical’ with little recognition for individual, clinically-informed approaches (‘an engineering approach’), and little professional support for the emotional impact of concentrated, direct engagement with others’ psychological distress.

RESETTING THE BALANCE

The apparent increase in levels of stress amongst psychological staff calls for an urgent and concerted action to secure compassionate and safe workplaces that are essential for quality of care. Cultures that support wellbeing are typically facilitative of accountable autonomy, reflective practice, participation in decision-making, staff engagement and creation of a non-discriminatory ethos, where difference and diversity are meaningfully sought alongside work-life balance. To create such cultures requires a joined up effort and responsibility of all those involved including politicians, policy makers, professional bodies, leaders, managers, experts by experience and frontline staff - working together for resetting the balance.

What do we mean by this? Our survey findings lend further confirmation to previous reviews, which have identified those factors that promote staff wellbeing. They raise a question about what is inhibiting the facilitation of compassionate work cultures that are essential to deliver quality of care. There is an urgent need, therefore, to understand and work through the barriers to collaboration between policy makers, managers and psychological services staff and consider how psychological services can integrate with other parts of the system. The further work must consider factors contributing to what emerges from our survey as an abdication of responsibility by employers, so as to formulate more constructive responses to poor morale, performance expectation and accountability. This will require both individuals and organisations to come forward to foster more compassionate workplaces, and develop responsible, reflective and mutually supportive systems where a better work-life balance can be facilitated. We are aiming to designate those who are seeking to do so as our Pathfinder sites. Above all what we mean by the call for resetting the balance is that ***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.*** This requires both individual and collective responsibility for resetting the balance. We must avoid the risk of turning the survey findings into a methodological debate as our staff are clearly telling us what is not working for them.

The survey results cannot provide all the answers to some difficult questions about how and why the interaction of psychological staff with NHS organisational systems is generating poor wellbeing. They are sufficiently worrying to invite urgent attention and a call for action. The Charter for Wellbeing and Resilience has been launched as a response with cross-party support and backing from a range of NHS and independent organisations. If the alarm and response that our findings have generated means that this issue is seen to be serious, then those who are willing to join forces to support the Charter can hope to achieve meaningful change. *“I take the findings of this survey very seriously because they show something is going badly wrong. I can’t be standing on platforms day in, day out, talking about a world-leading service if I’m standing on something that’s rusting away beneath me... It can’t be done unless [staff] feel valued and unless [staff] feel [that their] wellbeing is taken seriously”* (Alistair Burt, MP, Minister for Community and Social Care: New Savoy Conference, February 2016).

The Collaborative Learning Network led by the BPS and The New Savoy Conference is due to be launched in summer 2016. It aims to draw on the support for the Charter to facilitate more compassionate workplaces, shared learning and a network of influence by identifying local champions and pathfinder sites. The psychological professions are well placed to foster compassionate workplaces and improved quality of life for both patients and staff through their understanding of wellbeing and organisational cultures. Their expansion and transformation in recent years is to be wholly welcomed. At the same time, however, we must also pay attention to the culture they are generating for wellbeing at work for their own psychological staff. After all, stress at work does wear away compassion and engagement affecting quality of care, patient experience and outcomes. We must reset the balance on the front line so success can be achieved sustainably.

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