Clinical Psychology Forum

Special Issue:
The Francis Report
Clinical Psychology Forum

Clinical Psychology Forum is circulated monthly to all members of the Division. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.
THE FRANCIS INQUIRY report was published at the beginning of last year in February 2013 and reported the findings on the inquiry which took place, presided over by Robert Francis QC, into the causes of the failings of care which occurred within the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report made 290 recommendations, including openness, transparency and candour throughout the healthcare system, together with calls for improved support for compassionate caring, committed caregiving and stronger leadership in healthcare. A similar report, Trusted to Care, was published in Wales in May of this year.

Since the publication of those reports, all of us involved in healthcare: psychologists, physicians, nurses, allied professionals, social workers, administrators and others, have asked the questions, ‘How did this happen?’, ‘Why did this happen?’ and ‘What must we do to stop it happening again?’ Francis laid this out comprehensively. Julie Bailey CBE, in her comprehensive article, acknowledges change but stresses the need for more, particularly in the area of leadership. We are now adding a discipline-specific offering to the table.

Healthcare is a dangerous business, as those of us who work as clinical psychologists know only too well. And this is also an absolute case of, ‘There, but for the grace of God, go I.’ We are all fallible, we are all weak, we are all prone to stress, and we are all human.

But we also all happen to be psychologists, hopefully with particular insights into and understandings of human suffering – individual, marital, group, corporate and societal.

This special edition of Clinical Psychology Forum draws on those insights, and upon that detailed understanding that we, as psychologists, have – overlapping, of course, with the experience, knowledge and viewpoints of our fellow professionals. Thus, we have papers in this issue reflecting upon all the things that Francis concerned himself with: stress, compassion, compassionate care, culture, ethics, policy, social issues and the demands of psychological responsibility.

As difficult as the material contained within these pages is, I feel very at home here. Like most people navigating the lengthy course of snakes and ladders that marks the route to clinical psychology training, I spent much time as a nursing assistant in acute psychiatric hospitals and challenging behaviour wards in, and later – in company with Rachael Edge – on dementia wards as a trainee. With the benefit of those experiences, it becomes all too easy to imagine how it can be that stressed and burnt-out staff can end up in situations where they become guilty of, or complicit in, terrible and seemingly unforgivable things. But I learned too, as I developed a specialist interest in this area, how psychological interventions in the form of psychoeducation, supervision and Balint groups – akin to the Schwarz Rounds described by Barbara Wren in her piece – can relieve stress and burnout, promote job satisfaction and facilitate the development of compassion and the delivery of compassionate care.

When I became a trainee, Derek Mowbray – who writes in this issue on psychological responsibility – was my inspiration and my talisman. He foresaw a world of psychological leadership where consultant psychologists would lead all aspects of health services concerned with psychological provision, right across the spectrum. Alas, that world was not to be, although he remains my inspiration. The passing years have instead seen the diminution of our profession. Our professional structures have been eroded, badly impacting on numbers, our influence and impact on healthcare policy, and hence on our power to change things – not just in clinical psychology, but
across the whole of British psychology. We can change that. We must change that. As these pages show, we have – not all the answers – but several of them. We have so much to offer as experts, as clinicians, as leaders. You will find these pages inspiring. I did.

**Professor Jamie Hacker Hughes**  
*Clinical Psychologist, Neuropsychologist and British Psychology Society President-Elect*

**References**


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**The British Psychological Society**  
**DCP Wales**  
in collaboration with  
the Division of Health Psychology  
and the  
Division of Counselling Psychology

**Post Francis and Andrews:**  
*Psychological Approaches to Advancing Compassionate Healthcare Delivery in Wales*  

**SWALEC Arena, Cardiff CF1 1 9XR**  
**Tuesday 4 November 2014, 9.00am**

This event is aimed at healthcare managers, policy makers, assembly members and clinicians with an interest in developing compassionate healthcare systems, including approaches to supporting a resilient workforce.

There will be presentations from experts in the field of psychological approaches to healthcare as well as the development of patient informed services. There will be panel discussions and time for delegate participation. There will be opportunities for delegates to make links with other key players and discuss ways to take forward approaches within local areas.

**This is a free event and open to all, but places are limited so please book early.**

*This event is being financially supported by the DCP Wales Branch, which has invested in it for the benefit of its members.*

To register go to:  
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Editorial

Clinical psychology: Keeping the human in healthcare

Andrew Hider, Alison Beck & Richard Pemberton

This issue of the Clinical Psychology Forum focuses on the learning arising from the reports of Sir Robert Francis and associated inquiries and responses across the UK. The publication of these reports in triumvirate and in succession – Winterbourne, Francis, Andrews – are, we feel, an indication that things will not be the same again in the UK healthcare system. We believe that clinical psychologists, as senior, highly-trained healthcare professionals, share accountability with colleagues for addressing the issues contained within their pages. The key issues are all interconnected – patient safety, leadership, governance and staff well-being. Often, diagnosis and even prescription can be easy, but delivering effective solutions in complex healthcare systems is very hard to achieve.

These issues are directly relevant to a range of psychologists, across the divisions and faculties. In order to harness this wealth of experience, we set up a ‘Francis group’ e-mail group. This is a group of interested psychologists, many in senior healthcare positions with wider accountability for service delivery, who share ideas and practice. We have hosted conferences and liaised with divisional leadership, branches and faculties to share learning. This edition represents the culmination of this work. Hopefully, it will provide food for thought and, most importantly, a springboard for further debate and discussion. Ideally, you will join our Francis e-mail list (contact helen.barnett@bps.org.uk to sign up). It has been a struggle to gain formal BPS support and assistance, but we are hopeful that this is about to change. The new DCP policy officer, when appointed, is going to help shape the next stage of our work in this area and given Jamie Hacker Hughes’ foreword to this special issue, we are confident that additional cross-divisional support and BPS resources will be forthcoming. We would like your ideas about what we and the Society as a whole should be doing next to take this area of work forward.

In this special issue, we wanted to do three things: Firstly, we wanted to include a mixture of academic theory-driven articles, and pragmatic clinical articles, in order to reflect the profession’s role as a pragmatic discipline rooted in empirical science.

Secondly, we wanted to capture the contribution psychology makes in encouraging a focus on human concerns within modern healthcare environments that also, necessarily, have to be process, outcomes and resource driven.
Thirdly, we wanted to send a message to colleagues that we work alongside, from all disciplines, and to service users and their carers saying: ‘we are here, alongside you’ and ‘we have something useful to offer’. If we are to ensure that future history of UK healthcare is not going to be one of repeated scandal due to poor, neglectful or abusive care, inadequate governance, interdisciplinary conflict and poor staff morale, then we need to do something different.

We have made both the printed and extended versions of this issue freely available to all online. The articles in the online extended section have no less merit than those in this print version. We simply did not have space to include everything. We hope you will read and enjoy these thought provoking papers and that they will support our ongoing endeavours to improve the health and social care systems in which we work and, of course, from which we all receive care when we are vulnerable or unwell.

Dr Andrew Hider  
*Consultant Clinical & Forensic Psychologist, Ludlow Street Healthcare Group*

Dr Alison Beck  
*Trust Head of Psychology and Psychotherapy, South London & Maudsley NHS Foundation Trust*

Richard Pemberton  
*Chair, Division of Clinical Psychology*
WILL BEGIN this article about professional ethics and the Francis report with my own views about the root causes of poor standards of care. I have a social model (see, for example, Oliver, 2013; Wolfensberger, 1972) that is similar in some ways to the Francis inquiry’s, but with some differences (Francis, 2013). Francis, particularly Volume 3, was very close to the mark, when he reports that the culture of an organisation is a key issue, but I think he underplays the wider picture of the overall culture (including power relationships) in which we live and how organisations tend to reflect that wider context – one in which some groups and individuals are subject to powerful forces of social devaluation. This is then manifested in different ways, including poor standards of care. The inquiry notes:

One true measure of the NHS’s effectiveness in delivering hospital care can be found in how well the elderly are looked after. They are a vulnerable group, often unable to assert their rights and legitimate expectations for themselves, and have complex needs. It is a measure not just of our health service but also of our civilisation as a society. (p.1595)

This expresses something of this wider context, but maybe misses the point that even civilised societies will have these devaluing forces at play, placing people at risk. These are essentially moral questions and our professional ethical principles and standards can be one route for ensuring these vulnerable groups are protected.

My personal experience in evaluating service quality

My learning about these ‘root causes’ of poor care, and indeed my interest in professional ethics, goes back to the 1980s when I was involved in using a service evaluation instrument, Program Analysis of Service Systems (PASS) based on normalisation/social role valorisation (SRV) principles (Wolfensberger, 1972, 1991; Wolfensberger & Thomas, 1983). We were using this as a training tool, in which a group of participants would be taught the basic idea that groups and individuals could suffer serious harm through social devaluation and that by the same token could be protected against this by occupying valued social roles (Wolfensberger, 1991). Participants then spent some time in a care setting and rated the quality of its care against 50 standards, the majority derived from SRV theory. During these evaluations we would get to know one or two of the people using the service, and try and get a feeling for what life was like for them. The majority of settings were institutions for people with learning difficulties or mental health problems, or for older adults, and in general the overall picture was not at all positive. What we experienced on the visit to the care setting was very powerful as it had the effect of ‘unveiling’ our usual perceptions and allowed us to view it through this social lens of devaluation. Two experiences come to mind as illustrations.

In one setting for older people, I sat down next to a few people who were in a room that was like an expanded part of the corridor. It was very quiet except for the ticking of the clock.
I sat there for about an hour. During this time the things that took place have stayed with me. Every so often there would be the sound of foot steps and then the door would burst open and a staff member would walk in and brightly say a collective hello to everyone and then disappear through the other door and after this brief burst of noise it went back to the clock ticking. The only other event during this hour was when a woman was helped in by a staff member and sat down. Her handbag was placed in a chair out of reach. The staff member left. This clearly distressed the resident. She repeatedly called out for her bag, but nothing was done. I remain guilty for not fetching it, and then left the setting.

My second memory concerns a learning disability residential setting on bonfire night. There were no fireworks for the young people who lived there, but they (and we the visitors) all stood in the back garden trying to peer through a very thick hedge to see the village celebrations. It was very sad that they were separated in this way.

I have to say that I saw many much worse examples of care, but the above have remained with me as, while they were not as graphic, they are just the day-to-day devaluations that people in these groups experience. The SRV account of how these things happen makes good sense to me.

In another role as part of visiting teams with the Commission for Health Improvement and the Healthcare Commission (Commission for Health Improvement, n.d.) in the 2000s, going to mainly large general hospitals I similarly witnessed (in addition to excellent care) some very poor care, particularly on older people’s wards. I recall one staff member saying to me that the decor didn’t really matter, as the patients were ‘past their sell by date’. The reports we wrote laid the responsibility for this largely at the door of the Trust boards for not getting it right, and this, in some cases, resulted in the resignation of senior staff. While I had some hope that standards might improve as a result, I was much less confident in this analysis than in the one provided by SRV. Wolfensberger’s own recommended approach to dealing with poor care that people may experience in hospital is for individuals to voluntarily give their time to support and advocate for those they care about rather than hoping that government agencies will do this (Kendrick, 2007; Wolfensberger, 1992).

These societal processes of social devaluation have, of course, psychological aspects, and Mike Bender and I summarised some of these individual responses to people at risk of devaluation in a paper about dementia care: ‘So sad to see good care go bad – but is it surprising?’ (Bender & Wainwright, 2003). We wanted to make the point that it is likely that groups with these devalued identities will remain at risk and that it is not surprising that bad things happen to them. The research we quoted was from the social psychology literature (Asch, 1956; Festinger & Carlsmith, 1959; Milgram, 1974) to illustrate that the way we behave could best be understood as part of a much wider social framework. More recent studies of how we develop ethical blind spots are well described in Bazerman and Tenbrunsel’s work from the field of behavioural ethics as applied in a business context, which focuses more on, for example, cognitive biases (Bazerman & Tenbrunsel, 2011a, 2011b).

Organisational culture

Another important contextual strand that the inquiry noted was the presence of a bullying and intimidating culture that they said needs to be challenged. My reading of this, and from other points made in the report, is that there is a widespread problem of unethical behaviour among senior managers, arising from their being put in positions where they feel pressured to cut corners to fulfil contractual targets. The consequence has been toxic work environments where bullying and intimidation are not uncommon.

On 14 February 2014 in The Times, Robert Francis said: ‘A repeat of the Stafford Hospital scandal is still possible and it is “dangerous” for NHS staff to think otherwise’, and warned that health chiefs are still ‘bullying’ hospitals to hit financial targets at the expense of patient care, and says that ‘hospitals trying to put patients first will soon be deterred if behaviour like this is not stopped’ (Francis, 2014b).
That this is indeed a problem has been acknowledged for some time (see for example research on training of medical staff (Paice & Smith, 2009).

Sir Ian Kennedy is another outspoken critic in this area. When Chair of the Healthcare Commission, he stated that: ‘A bullying culture in the NHS is permeating the delivery of care… One thing that worries me more than anything else in the NHS is bullying’ (Santry, 2009).

This issue is one where ethics can quickly become compromised – indeed, bullying itself is unethical. It leads to people being fearful of acting in a way that is in conflict with their management colleagues, and to whistleblowing becoming the only option. As a follow on to the Mid Staffordshire inquiry, Robert Francis is now chairing the Freedom to Speak Up Review (Francis, 2014a), described as an independent review into creating an open and honest reporting culture in the NHS. The aim is that: ‘Those who speak up when things go wrong in the NHS should be welcomed for the contribution they can make to patient safety.’

It is a commentary on all the previous initiatives and their surrounding rhetoric that this is still needed, and leads me to return to the point that wider social and political forces are at play that need to be addressed.

Professional codes of ethics and conduct, clinical psychology and management

So how can we link this context of culture and values to professional ethics and in particular the British Psychological Society’s (BPS) Code of Ethics and Conduct? In the introduction to the Inquiry a central concern is indeed compliance with professional codes of ethics and conduct. Francis says of the role of the professions and their compliance with their own professional standards:

As has been frequently pointed out to the inquiry, the primary responsibility for allowing standards at an acute hospital trust to become unacceptable must lie with its Board, and the Trust’s professional staff. The system is designed for directors to lead and manage the provision of services within its allocated budget but in accordance with required standards, and for professional staff, informed by their ethical standards and commitment, to serve and protect their patients. If every board succeeded in that challenging task, and if all professional staff complied at all times with the ethics of their professions, there would have been no need for the plethora of organisations with commissioning and performance management responsibilities. (Page 14, Part 1, Introduction – emphasis added).

As professional psychologists this asks us to consider why we might not comply at all times with the ethics of our profession. It also has implications for the function of the BPS. In the current regulatory framework, how does the BPS act to support its members complying? In what way could it enhance its current role to promote an ethical culture in which professional staff working to their codes of ethics and conduct would be actively promoted by the organisation, with a strong focus on putting the patient first, as Francis argues in the above quote.

In many Trusts, professional leadership has been weakened over the past few years. Perhaps the time has come to use the opportunity created by the inquiry to review this, and for the DCP (and the Leadership and Management Faculty in particular) to link its strategy for strengthening local professional leadership to the promotion of an ethical culture within the NHS.

This could be linked to another recommendation in the inquiry: that all managers should be signed up to a code of ethics, and perhaps we could see a joint project of supporting managers and clinicians in complying with these principles. The use of codes of ethics is now widespread and the evidence generally support their use (The Center for the Study of Ethics in the Professions, 2013).

This recommendation fits well with the work of Professor Derek Mowbray, clinical and organisational psychologist, who has consistently argued that implementing a management code is badly needed and that it is primarily this implementation aspect that is the problem. He produced a Code for Managers (Mowbray, 2014) which has now been incorporated into the Institute of Healthcare Management Code and was formally adopted in
January 2012. An excellent presentation outlining the rationale for the code and its purpose is given in a presentation by Dame Carol Black (Black, 2012), Expert Adviser on Health and Work at the Department of Health, at its launch. At the end of her talk the last slide says: ‘Please use the code’. Clearly, unless the code is used it will not have much impact, and implementation is going to be key here.

Another body that has taken this on is the Professional Standards Authority – the regulator of regulators. They have published a code which sets out standards for members of NHS boards and clinical commissioning groups – the governing bodies in England (Professional Standards Authority, 2013).

It sets out the following principles for managers and they have a familiar ring, being very similar to the BPS’s Code of Ethics and Conduct:

- responsibility;
- honesty;
- openness;
- respect;
- professionalism;
- leadership; and
- integrity.

I have not been able to clarify the mechanism for these codes to be implemented or how managers may be held to account. Whatever emerges in that context, however, we have a golden opportunity for collaboration between our own professional body (whether the DCP or the BPS) to make the NHS a thoroughly ethical place to work and deliver services. Such codes, backed by professional bodies like the DCP and the Institute of Healthcare Management, provide a possible way to resist unethical political demands. It would suggest that now would be a good time for the cultivation of ethical communities in NHS organisations across all professional groups, including managers, who are often put in situations where their ethical standards can be compromised.

Implementation

This special issue could be a game changer in how the DCP links practice to action, as the inquiry gives us permission to intervene as professionals in the cultural landscape of health and welfare which may have hitherto appeared to be too political for us as a professional body. Francis is very clear: we have an ethical duty to act and this may mean taking on powerful vested interests and societal value systems if we are to have any real impact on quality of care.

Dr Tony Wainwright

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The British Psychological Society

Psychosis & Complex Mental Health Faculty Conference & AGM

Developing the Narrative 2:
Putting the New Narrative into Practice

BPS London Office, 30 Tabernacle Street, London EC2A 4UE

Tuesday 4 November 2014, 9.00am–5.00pm

Building on last year’s successful gathering of allies, we are taking the process a step forward with an opportunity to engage with the challenge of embedding the new narrative into everyday clinical practice. Real life examples of how this can be done will be provided by Lucy Johnstone (Formulation in teams), Russell Razzaque (Open Dialogue project in the UK), Spiritual Crisis Network (a completely different take on psychosis), along with workshops focused on innovative research and practice.

The New Paradigm Alliance

Taking forward last year’s themes of building alliances and creating visibility for a new approach to mental health in the public sphere, we will be introducing and discussing the New Paradigm Alliance.

Free event for Faculty of Psychosis & Complex Mental Health members only.

This event is being financially supported by the Faculty of Psychosis & Complex Mental Health Members, which has invested in it for the benefit of its members.

The PCMH AGM will be at the end of the day at 4.30pm.

To book go to:
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All queries, please e-mail MemberNetworkServices@bps.org.uk with ‘PCMH narrative 2’ in the subject line.
THE EXPERIENCES of patients reported by their families in the Mid Staffordshire inquiry were shocking, disturbing and bewildering. It is difficult to hear and believe that people were not given food or water, and were allowed to lie in their own filth. These experiences were reported second hand by patients’ families. What if it had been you? Or me?

Well, as it happens, one time on admission to a psychiatric ward, having been a vegetarian for a decade and not having eaten for some time, I was given liver at mealtime. There were no other options. No-one seemed to know or care that I was a vegetarian. I ate the liver and that was the end of my vegetarianism, along with my belief that I had the same rights as people outside the hospital.

I am not comparing this experience to that of those at Mid Staffordshire, but each time I was in a psychiatric hospital there were many occasions where myself and my fellow patients were treated in ways that suggested we were of less value than others.

Francis witnessed descriptions of ‘bad care, denials of dignity, unnecessary suffering’, and advocates that ‘people must always come before numbers’. He said that the provider Trust board ‘...did not listen sufficiently to its patients and staff’.

For many people, listening is a straightforward thing – you either are or you’re not. Psychologists know that it is more complicated than that. Listening occurs within power relationships. Some are more powerful than others. How welcoming is a nurse of a patient’s reflection on their care? How likely is a patient to express their opinion to the carer they are dependent on and at the mercy of? How possible is it for a nurse to talk to their manager about how easy it is to deliver care within the current system? What about the managers? Do they find board members eager to hear good and bad news? Psychologists can help to understand these relationships and how they relate to effective communication. At the heart of it must always be how the system puts patients first.

Francis advocated openness, transparency and candour. There is no point in being honest and open if there are negative repercussions as a result of it. The great irony is, do we trust the NHS Trusts? Do the employees trust their managers and the board? It is only as greater trust develops that these workplaces will become stronger and more effective at tolerating truth. Would there be some way of using the lessons of the truth and reconciliation commission in South Africa?

We cannot complacently scapegoat Mid Staffordshire and leave it at that. This scandal came on the heels of Winterbourne View, the latest of a long list of services for people with intellectual disabilities where there were serious problems. As I talk to people who have used services I hear stories of people whose lives have been saved by fantastic services. I also look at the psychiatric ward where patients hover outside the staff door waiting for someone to speak to, with eight staff in the office ignoring them; many patients on this ward no longer having the courage to even knock on the door, others driven by frustration to walk right in. The system seems puzzling and unhelpful.

There is a worrying tendency where those who are not part of systems are described as exhibiting ‘challenging behaviour’. Is this term now being misapplied in mental health care with the meaning becoming pejorative? A nurse on a general ward recently described how they have many patients with ‘challeng-
ing behaviour’. If the way the system relates to me causes me to feel frustrated and I express that, then am I labelled as showing ‘challenging behaviour’? Then what? Has psychology given this expression to nurses, to schools to the world? What sort of responsibility goes with this?

As psychology departments have been reduced it has become increasingly difficult for clinical psychologists to feel that they are supported by like-minded colleagues. There is an opportunity, by engaging with the DCP right now, to ensure that you are supported, to have your voice heard, and to ensure the people who use your services and the staff you support have their voices heard too.

It is essential that we do not get sidetracked by the red-herrings of the intellectually fascinating or the areas that we feel most comfortable with as we grapple with the thorny issues raised by Francis. Yes, there is a role for looking at leadership – providing that there is a clear link with how this improves patient reported experience. Yes, there is a role for looking at values and culture in organisations – providing, again it can be demonstrated that this indeed improves patient reported experience.

Where is the consideration for how we hear the patient voice, how we ensure that we know what sort of experiences patients are having? The British Psychological Society’s work on Francis needs to be knitted together with our strategy for connecting a network of people who have used our services, in a hub and spoke model. In England these networks will be focused around the regional branches (the spokes) and then from this there will be potential candidates to sit on the hub committee, which will work alongside the DCP Executive Committee. This model will ensure that the DCP is able to take Francis and other crucial work forward in a way that we may stand a chance of preventing further tragedies in the future and create services that we are truly proud of. If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics, benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented.

Joanne Hemmingfield
DCP Lead for Service User and Carer Involvement in England

Reference
THIS IS A REFLECTIVE piece on my experience as a trainee clinical psychologist working on an in-patient dementia ward. I consider my process of adapting to this placement, and the challenges psychologists face in dementia wards.

I recently completed a placement involving one day a week on an in-patient dementia ward, which was a completely new experience for me. I hope that my reflections on this experience are useful for others working with this client group. This account, whilst subjective, may be relevant for others who find themselves on an in-patient ward, whether as staff, patient or visitor. Consideration of the challenges in providing psychologically-based care to these clients may also be of benefit to those currently working in this setting.

My initial expectations of the ward were shaped by various factors, including media representations (fictional and factual), stories from my colleagues in training, and my own personal values around safety, mental health and involuntary hospitalisation. I felt apprehensive – uncertain I could feel comfortable in a ward environment, yet also enthusiastic about working with this client group, for whom I feel a great sense of compassion.

**Chaos and anguish**
My first experience of the ward was an unfair representation of ward life. It confirmed my fears of a chaotic environment steeped in distress where I would feel unsafe and helpless to help others. Intending to ‘ease me in’, my supervisor invited me to the ward multidisciplinary meeting (MDM). During the four hour meeting, I was shocked by the shouting and commotion occurring outside – chaos leaking into the meeting through the distress of family members who attended, crying and shouting at one another. I had expected distress but not to this extent! The other professionals did not overtly respond to this anguish, so following suit, neither did I.

Trainees often gain a privileged insight into placement environments; their ‘outsider’ perspective, combined with curiosity and reflexivity developed through clinical training, enable observations of systems which may be unseen by those within. During the MDM, it appeared that staff must contain a great deal of the distress of others, in order to make difficult decisions and provide care, while coping with this distress themselves.

I wondered what strategies staff used to cope with the emotional impact of turmoil and distress, which may become ‘the norm’ for them. Kitwood (1990) describes some of the detrimental strategies that staff use when working with people with dementia, such as detachment – losing touch with the person as a human, potentially causing objectification. Staying attuned and empathetic in an environment where there appears to be so much distress may therefore be a challenge. It seems important that staff are supported in coping with the emotional impact of their work, particularly those who may have received less training and feel less a part of the staff team, such as agency staff.

**A multifarious existence**
My second visit to the ward revealed a very different aspect to ward life. The woman who had been at the centre of much of the commotion days earlier was now quiet and subdued, appearing pensive as she waited for
her husband’s visit. The gentleman whose family had been so conflicted during the MDM was being doted on by the same family members, their disagreements replaced by tenderness and love. Another gentleman overcame language barriers to joke with staff, miming and smiling.

Over the coming months, I noticed this contrast between chaos and harmony, frustration and moving moments of poignancy. Safety had been a concern for me, yet I was able to notice when the ward felt ‘charged’, often after a difficult morning for a patient, and which indicated further distress was likely. On days when the ward was quiet and calm, staff feared jinxing this fortune – scolding, ‘don’t say that!’ when I highlighted the quietness. Staff appeared to believe that calm days occurred through luck, not through their own attunement and empathy for their patients’ needs. Perhaps downplaying their own impact on the ward environment made it easier for staff to tolerate distress when it did emerge – this being ‘bad luck’ rather than anything within their control. My curiosity as a trainee encouraged staff to reflect on how their actions may have contributed to ‘good days’, emphasising the positive impact they could have. The ‘good times’ seemed important for staff to keep the person behind the ‘dementia patient’ in mind, and in helping staff to cope when things weren’t going so well.

Each time I left the ward, I felt acutely conscious of my freedom compared to those in hospital under the Mental Health Act. I wondered how it would feel to leave one of my parents there, particularly during times when the environment was highly emotional or ‘charged’. These reflections diminished the longer I worked on the ward, and I suppose those working there daily rarely think of this. Yet it strikes me that these are the things we must hold in mind if we are to retain the person behind the ‘dementia patient’ we walk away from at the end of each day. This empathy was sometimes difficult to spot, but at other times, it shimmered behind heartfelt conversations between staff who considered how they would feel if they were in the position of their patients’ loved ones, or what they would be like if they had dementia.

A process of cultural adjustment occurred for me. I learned to tolerate chaotic moments on the ward by keeping in mind the person feeling distressed and using the information I gathered to make recommendations. I was able to acknowledge the distress that could be heard during MDMs in a contained manner, that I felt comfortable with, by making sympathetic utterances, and noticed others doing this as well. These responses involved remaining in touch with the person, rather than distancing from them.

When my placement ended, I felt confident, competent and valued – inspired to ‘bring the person back’ when talking with staff, writing reports and contributing to meetings. This is a strength of clinical psychology within acute dementia, where individuals can be viewed as challenging or hopeless. Trainees especially can curiously explore established organisational attitudes and practices, encouraging reflection and perspective taking.

**Context and climate**

I became aware of some ambivalence towards clinical psychology input, which had unfortunately been limited at times, with periods of no psychologist due to staffing and organisational changes. This is a common occurrence nationally within the current climate of austerity; limited budgets mean NHS resources are stretched, including clinical psychology within acute care (DCP, 2012). Indeed, once my placement ended, there would be no psychologist on the ward for a time. Coupled with this transience of psychology, was the inevitable inconsistency in staff collaboration due to changing shifts. I visited the ward twice weekly, but it was likely that any one staff member would not see me for longer than a week. It was no surprise then, when one staff member commented, ‘We’ve coped without psychology before’, and while this is likely to be true, ‘coping’ may involve tolerance and stasis, rather than empathy and improvement.

**NICE (2006)** recommends psychological approaches when addressing challenging behaviour in dementia; such approaches can improve quality of life for those who are reliant on others to provide this. While ward
staff appreciated psychological recommendations, applying interventions consistently and in a sustained manner was difficult due to the challenge of doing this across staff shifts and staff members, which often included agency staff. Effective intervention arises from collaborative formulation of difficulties, with staff ownership of interventions – it can therefore be difficult to consistently apply ideas that some staff may not have had the opportunity to collaborate with, and which may seem imposed, rather than helpful.

Psychology on in-patient wards may often be viewed as secondary to patients’ physical needs, and as something which there frequently isn’t time for. Paradoxically, the times when psychology began to have an impact appears to be when psychologists had a greater and sustained presence on the ward, This perhaps highlights the need for psychology resources within some ward teams, in order for effectiveness in collaborative psychological interventions. At present, however, psychologists may be seen as visitors, as they are not based within ward teams and are often split between services – appearing an ‘add-on’ to the essential in-house ward service.

**Mutual benefits**
The complexity of ward environments may initially be overwhelming for trainees; however, exploring this system with curiosity, supported by supervision, can enable reflections on personal and systemic levels, benefiting both trainees and placements. Regular, frequent, and sustained psychology input, which is supported and enhanced by key ward staff, may increase the effectiveness of interventions, improving both patient conditions and staff morale.

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LIKE MOST people in the UK, I was brought up to believe in the NHS. Hospitals are safe places where doctors and nurses will be there to care and make us better, if they can. All that was shattered for me after spending eight weeks on Ward 11 at Mid Staffs in 2007.

What I saw during those weeks still haunts my dreams today and I suspect always will. I had no idea that a hospital ward could be so unsafe and so uncaring and I had no idea that Mid Staffs wasn’t an isolated case, and that I wasn’t alone in my search for answers.

On this anniversary we must remember that many people were harmed at Mid Staffs and families have been left devastated by how their loved one suffered. Further damage was caused by how the NHS treated them afterwards when they complained about poor treatment.

Much has changed in the NHS since Mid Staffs and the subsequent Francis inquiry. Things are changing for the better and the NHS is more transparent with its performance, but the culture of denial identified by Sir David Nicolson when he gave evidence to the Public Accounts Committee in 2013 is sadly still thriving.

Our group, Cure the NHS, helps those who believe they or their loved ones have been harmed unnecessary within the NHS. It’s disappointing that this culture of denial still exists, but it does. Families want to know that when a mistake has been made, lessons have been learnt and it won’t happen again. Organisations still fear litigation instead of promoting candour.

A sudden unexpected death is hard enough to deal with, but when you feel that the truth hasn’t been told it adds to the torture. My mum was 86 years old and expected to die, but that didn’t make it any easier. It was the way she died and the denial afterwards that has made grieving difficult.

Sir Liam Donaldson said as far back as 2009 that: ‘To err is human, to cover up is unforgivable, to fail to learn is inexcusable’. This still challenges facing the NHS today and I deal daily with the consequences.

One woman who I assist has actually been to prison for wanting answers to her husband’s death (Daily Mail, 2012). She is still searching for answers many years later; still turning events over and over in her head, trying to make sense of what happened. I hear from many in a similar position, stuck in a stage of the grieving process unable to move forward. Damaged by people they had so much trust in and were socialised to.

We give little thought to those who have made a mistake and harmed a patient. Danielle Ofri, writing about the emotional side of medicine, rightly points out that we spend time creating new system approaches, relabelling medication, and so forth, to deal with medical errors, but instead we need to bring them out in the open and talk about them (Ofri, 2013).

How difficult is it for a clinician/nurse when they fear admitting a mistake has been made? An admission that isn’t easy in the first place, but even harder when the values within the organisation don’t welcome candour.

At the Mid Staffordshire Public Inquiry we heard that speaking up and out about errors wasn’t encouraged. Also highlighted recently by Robert Francis, who is chairing the review Freedom to Speak Up (www.freedomtospeakup.org.uk) to ensure those that raise concerns within the NHS around patients safety can do so safely.

Creating a safe learning environment is a leader’s role within the NHS. Where errors can be made and talked about and learnt from to ensure they don’t happen again, the public expect nothing less.

Until the NHS creates this leadership and environment, I will continue to hear from...
poor souls who struggle to find answers and torture themselves trying to do so.

We don’t go away, some will continue to search for answers, possibly forever. Others, like myself, can help to work towards a safer NHS. I have Cure the NHS and my family to thank for giving me the support and strength to do that; others haven’t that luxury. I have found the system offers little in the way of support for the public or its staff, and that must change.

I hope a safer NHS for patients and staff will one day be the Mid Staffs legacy. Where to err happens, covering up doesn’t and not learning from a mistake is a never event.

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Cure the NHS
Julie Bailey is founder of Cure the NHS, a group she established in December 2007 after the death of her mother in Mid Staffs Foundation Trust Hospital. The group successfully campaigned for a public inquiry into the failings at the hospital and the wider NHS.

Cure the NHS offers support and advice to people throughout the country who have been harmed within the NHS and the group has recently become a small charity.

Julie speaks to a wide range of audiences and has been working with leaders from England, Scotland and Wales. Her book From Ward to Whitehall: The disaster at Mid Staffs captures the struggle she had to be heard to help to expose systemic failings within the NHS.

Julie was awarded a CBE in the New Year’s Honours list for her services to older people. She was recently awarded 2nd place in the Woman’s Hour Power List 2014, as one of the top game changers operating in the UK today. The group continues to campaign for a safer NHS for patients and its staff.

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VER THE PAST few years many organisations have been exposed as having serious issues around culture, leadership, whistleblowing, the interface with customers, clients and patients, the behaviour of staff with each other, the disengagement of the workforce from work and their employers, and the disconnection between staff and managers. This adds up to concerns about the workforce and raises questions about its capacity to provide high quality and effective services in the context of such discontent.

Engagement between a person, others, their work and their employing organisation is known to improve performance. Social engagement, also known as affective engagement, is characterised by vigour, dedication and absorption, and is a feature of positive working cultures, good leadership, good working environment and resilient people. Social engagement is a goal worth aiming for, not only because of improved performance, but because the processes of attaining this form of engagement involves the reduction of psycho-presen
teeism – people being present at work in body but not in mind – and the associated costs, normally between one and a half and two times the combined costs associated with sickness, absence and attrition attributable to psychological distress. The Organisation for Economic Co-operation and Development (OECD, 2014) calculated the total cost of mental health issues including presenteeism in the UK to be £70 billion per annum.

Calls for a change in culture are now frequent, with the most recent being that from the Public Administration Select Committee in April 2014, over the public sector handling of complaints from the public.

Recommendations on how to change culture and transform the public sector have come from various sources, including (with respect to the NHS) the Mid Staffordshire NHS Foundation Trust Public Inquiry Report, followed by a A Promise to Learn – A Commitment to Act: Report on improving the safety of patients in England, both published in 2013 and both of which identified the catastrophic consequences of dis-engagement.

The impact of challenges facing the workforce in the NHS had been brewing for a number of years preceding these reports, as shown in the NHS annual staff surveys and other major inquiries.

Amongst several initiatives to change and transform the NHS into a positive working culture that predate these reports was the publication of the Code of Conduct for Managers in Health and Social Care, based on the work of the author, launched by Dame Carol Black in January 2012 on behalf of The Institute of Healthcare Management. This code set out behaviours to achieve commitment, trust and engagement between managers and the workforce, leading to a culture based on psychological well-being and performance. It was a piece of work that involved all the major professional organisations, including the BPS, trade unions and representatives of the Welsh Government and the Department of Health. Efforts to promulgate this code as the NHS code have been thwarted (probably as a result of being caught up in the discussions about manager regulation and licensing), giving rise to speculation about the commitment of senior people in the NHS to genuine culture and leadership change, as this was the focus of the code.

Psychological responsibility
As part of his continuing development of approaches to transforming cultures, the author has brought together under a single framework (the WellBeing and Performance
A genda) the behaviours and actions that are known to trigger responses that can lead to individual and corporate peak performance as a consequence of embedding psychological well-being in the workforce. One of the main pillars of this framework is social engagement. The WellBeing and Performance Agenda depends on the workforce adopting behaviours that trigger trust, commitment, engagement and kinship in others, as these are evidenced as being the behaviours that reduce the risk of psycho-presenteeism and encourage psychological well-being.

Introducing into organisations the idea that everyone needs to behave in certain ways is a substantial challenge requiring changes in attitude by managers towards the workforce. The change needed is from approaches that exploit to approaches that nurture.

The global project to encourage organisations to adopt ‘social responsibility’ (a responsibility for their impact on the environment) has had a major impact on the way businesses and services have changed their attitude towards their engagement with local communities. Those businesses and services that have adopted social responsibility are amongst the most successful in the world.

The idea of social responsibility has spawned in the author the idea of psychological responsibility which aims to encourage everyone at work (and elsewhere) to change attitudes towards themselves and others with whom they engage. The ultimate aim is to attenuate the risk of psycho-presenteeism, improve social engagement and provide the opportunity for improved or enhanced personal performance.

Encouraging everyone to adopt psychological responsibility is a process that requires people to think about themselves and their impact on others. It is also a process of developing a psychological culture, one that has the interests and well-being of people at its centre.

The slogan that accompanies the psychological responsibility headline relates directly to the behaviours needed to enhance the opportunity of the workforce to achieve output behaviours of commitment, trust, social engagement and kinship at work. These output behaviours, when people are encouraged to focus on work using motivation and provoking concentration, produce high level performance:

- **Think independently** is linked to Attentiveness and Intellectual flexibility.
- **Be attentive** to others links to attentiveness and encouragement.
- **Act with humanity** links to attentiveness, reliability, conflict resolution and encouragement.

Responsibility is how people feel. People take it upon themselves to feel responsible for their own actions by being accountable to themselves for them. Therefore, people who take psychological responsibility need to feel accountable to themselves for their own psychological welfare as well as being accountable for their impact on others.

This has been shown to be a powerful technique in encouraging people to think before they act and behave. Simply talking about psychological responsibility makes people more aware of their own behaviour and the behaviour of others. It is the beginning of a process to bring a cultural shift towards nurturing the workforce as opposed to exploiting it. Nurturing people enhances their psychological well-being. The process involves triggering key features such as, for example, attentiveness, challenges, encouragement, career progression, involvement and openness.

People who feel psychologically well perform better than those who don’t. Feeling exploited, however, does the opposite. If a person feels exploited this plays to negative influences on attitude, on being personally valued, on self-esteem and self-worth. For those organisations seeking to perform at their peak, exploitation is to be avoided. In the NHS, the current excess squeeze on money, and the increased demand for more from less, combined with the reshaping of jobs and grades, gives rise to a sense of exploitation.

The idea of psychological responsibility also helps to counterbalance the emergence of the isolation, frenetic experiences, quick fixes and
Psychological responsibility

The impact of social media on relationships by encouraging individuals to think about other people, about the impact we have on each other, and how this impacts on our psychological well-being as well as that of others.

Psychological responsibility has a link to mindfulness, which is about being in the present. Mindfulness is also about taking responsibility for your own thoughts and feelings in the present. Used as a means of delaying reactions to events and other people, mindfulness acts as a moderator for behaviour and can calm people down in the face of a challenging event or difficult behaviour.

In the workplace, when everyone adopts psychological responsibility they start the processes of being attentive to others; the processes of creating and sustaining trust, commitment and engagement. These behaviours play to psychological well-being and the reduction of psycho-presenteeism. The benefits that arise include improved performance, the prevention of psycho-presenteeism, a reduction in costs associated with psycho-presenteeism, sickness, absence and attrition, and the creation of a culture that provokes social engagement, with the consequences of vibrancy, innovation, adaptability, corporate resilience and peak performance.

Psychological responsibility on its own isn’t sufficient to bring the cultural and leadership changes the NHS needs. Embedding psychological responsibility in organisations requires the implementation of The WellBeing and Performance Agenda. This agenda is designed to enable organisations to achieve peak performance by sustaining psychological well-being in the workforce.

**The WellBeing and Performance Agenda**

The WellBeing and Performance Agenda transforms first level behaviours – attentiveness, reliability, intellectual flexibility, conflict resolution and encouragement (psychological responsibility) – into second level output behaviours (commitment, trust, engagement, kinship, motivation and concentration).

The overall process is shown in Figure 1. It involves introducing *input behaviours* into organisations using the WellBeing and Performance Agenda to produce the *output behaviours* that provoke commitment, trust, engagement, kinship, motivation and concentration. The result is the potential for peak performance from individuals and the organisation.

The underlying principle of the WellBeing and Performance Agenda is ‘sharing responsi-
bility for the future success of the organisation’. This is the focus for each of the elements of the agenda.

The elements are: adaptive culture, adaptive leadership, adaptive working environment, and the adaptive and resilient person. Each element has specific activities and actions to be put in place that reinforce the utility of the psychological responsibility behaviours in achieving psychological well-being and performance. These are shown in the figure.

Adaptive leadership, for example, is based on ‘sharing responsibility for the future success of the organisation, and is a process that ensures that all members of the workforce have the organisation and its future as their focus, not the requirements of managers. The ingredients that make this happen include:

- independent judgment is expected;
- elephants in the room are raised and dealt with;
- reflective and continuous learning is institutionalised; and
- leadership capacity is extended.

A distinction is drawn between technical challenges for which solutions are known and adaptive challenges for which solutions are speculative.

As so many organisational challenges are adaptive, the need to capture the combined intelligence of the workforce is an essential ingredient to reaching decisions which reduce and limit their ambiguity. Adaptive leadership processes eliminate the need for people to whistleblow.

The role of managers becomes that of a conductor of a choir, ensuring that all parts contribute effectively, whilst allowing each person to interpret the music and critique the contributions of others if they are felt not to be contributing to the overall success of the piece. In effect, each member of the choir acts as though they are the conductor, whilst recognising that one person has the oversight and needs to bring everything together.

There are certain behaviours needed to make this happen without everyone descending into chaos.

**Psychological responsibility behaviours**

The behaviours are those that provoke commitment, trust and engagement in others.

- **Attentiveness** – Arguably the most important behaviour to demonstrate. If someone is attentive to you, and you feel they are being attentive, it is almost impossible not to reciprocate and to be attentive in return. This is the essence of successful interaction, but requires considerable skill, concentration and practice. Clinicians will argue that attentiveness is essential in the clinical setting to ensure appropriate assessment and treatment. Managers, however, tend to find attentiveness more difficult to achieve, as they are often more concerned about putting over their point to others than considering the thoughts and feelings of those with whom they interact. This can apply to others in the workforce whose consideration of others may not be at the top of their own personal agenda in interaction.

- **Reliability** – Strongly linked to trust, which is derived from reliability. Trust is the absence of second guessing the motivation of others. Trust occurs when we take people at face value and expend virtually no resources in working out the persons’ motivations for actions and what they say. We rely on people we trust. Reliability, leading to trust, is demonstrated by consistency of openness and transparency.

- **Intellectual flexibility** – A capacity to ‘think on your feet’. This requires being able to think independently and respond to any situation by demonstrating thoughtful responses which are not obviously aligned to a known agenda. When this occurs, it is also a sign that those engaged in an interaction are ‘free’ to think independently.

- **Conflict resolution** – The capacity to negotiate in an interaction and, where necessary, arrive at a compromise when a conflict is anticipated. This requires considerable skill, concentration and practice, as well as attentiveness and understanding the self-interest of others.

- **Encouragement** – The support provided from one to the other in interaction to say and do things.

**All the behaviours add up to humanity** – Tending and befriending others, in an envi-
Psychological responsibility

Environment of reciprocal kinship which contributes to mutual psychological well-being.

Implementation

The words ‘psychological responsibility’ conjures up many possible interpretations, and in many ways this doesn’t matter. Introducing the words into everyday discussion at work has an impact and makes people stop to think about what it means.

To date, the implementation of this idea has been part of the implementation of The WellBeing and Performance Agenda. This involves three stages of implementation – raising awareness of all the challenges and possible solutions using the agenda (for example, by presentations and workshops; implementing the agenda which follows the strategy of conviction and uses action research and learning methods; and mentoring internal champions for change and coaching in behaviours – e.g. instead of saying ‘I am going to talk to Miss Smith’, say ‘I am going to listen to Miss Smith’). The third stage is embedding the agenda, which uses methods to reinforce change, such as ensuring the elements of the agenda are regularly reviewed by managers with their teams.

However, there is no reason why the implementation of psychological responsibility should not be a stand-alone project. Whilst it will not transform culture and leadership on its own, it starts the process of change. This could involve the introduction of cards as a way forward with the slogan for psychological responsibility conveying its meaning. If every member of staff had a card with psychological responsibility and the slogan printed on it, it would provide a physical reminder of what is expected in practice. Implementing the idea also requires articles to be written in newsletters and elsewhere, so that it becomes a common phrase. It requires managers to place psychological responsibility on the agenda for their meetings with staff, and to encourage discussion about where the idea has made a difference to relationships between staff and between staff and their clients or patients.

Psychological responsibility could also become a unifying feature for applied psychologists. Adopting the words could become a unifying purpose for applied psychologists working inside organisations and other communities – a purpose that is ultimately intended to change attitudes towards people and raise the level of consciousness about the importance of attentive and humane interactions.

Conclusion

Psychological responsibility is an idea to assist with transforming culture in organisations from one of exploitation to one of nurturing and social engagement. This is achievable in any organisation if people think about their interactions with others.

Such an approach has an impact on the workforce, and in conjunction with implementing The WellBeing and Performance Agenda, would have reduced the risks of behaviours highlighted in recent inquiries in the NHS.

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STAFF EXPERIENCE is at the heart of organisational culture in the NHS and intimately related to patient experience (Maben, 2010). The drive to improve organisational culture derives to a great extent from the concern that patients have suffered needlessly and their clinical outcomes been compromised while using healthcare services (Francis, 2013). National data from staff surveys and other sources tell us that staff are suffering too (Berwick, 2013; Ballat & Camping, 2011). Constant change, job cuts, insecurity and increasing work volume are creating high levels of anxiety in healthcare organisations. Anxiety is managed through various means, some more functional than others, that can be broadly categorised in terms of creating defences and/or creating meaning (i.e. creating a distance between oneself and what is difficult, or making sense of what is happening). This happens at both an individual and an organisational level (Obholzer & Roberts, 1994). It is through helping organisations to understand the impact of this anxiety and manage it in a reality-based way that psychologists can make the greatest impact on organisational culture. Schwartz Rounds are an organisational intervention in which the management of anxiety and the management of meaning come together in a group exploration of the psychological impact of work and of organisational culture on both troubling and rewarding staff experiences.

Schwartz Center Rounds (The Schwartz Center, n.d.) originated in the US and provide a forum for healthcare staff to come together once a month to explore together the non-clinical aspects of caring for patients – the psychological, social and emotional challenges. They were piloted in two UK sites (the Royal Free London NHS Foundation Trust and Cheltenham and Gloucester Foundation NHS Trust) and more than four years later are still running successfully in both hospitals.

Each Schwartz Round lasts for one hour and includes a presentation of a patient experience by a multidisciplinary panel who go on to describe the impact that the patient experience has had on them. A typical panel will include 3 or 4 staff, all involved in a case, who will each describe their unique experience of it. Occasionally, Rounds are theme rather than case based. For example, ‘A patient I’ll never forget’, when each presenter describes a patient from their past and why they had such an impact on them. Once the panel have presented, a facilitator and a medical lead (who jointly facilitate the Round) help the audience to make a connection between the stories they have just heard and similar experiences of their own. The Round then becomes a group reflection on work experience with the facilitators creating links between the stories that are shared, and drawing out personal, professional and organisational themes that emerge.

The implementation of Schwartz Rounds has been recommended in the Department of Health’s response to the Francis inquiry. The Point of Care Foundation (www.pointofcarefoundation.org.uk) is now rolling out Schwartz Rounds across the UK and provides...understand the impact of this anxiety and manage it in a reality-based way.
support, mentoring and training to new organisations starting Schwartz Rounds. The author works with the Point of Care Foundation as Lead Mentor and Psychologist, and has developed the training and mentoring model that is provided to healthcare organisations to support successful implementation of Schwartz Rounds (see Wren, 2012, for a further discussion of these points).

Schwartz Rounds at the Royal Free
The Rounds take place once a month in a neutral setting, a large meeting room where high profile meetings are held. The day of the week is varied to increase their accessibility to staff on different shifts. While the Round starts at 1.00pm, lunch is available for staff from 12.30pm and has been shown to be an important part of the experience of the Rounds, highly valued by staff and providing an opportunity for discussion, support and reflection on the Rounds. The Rounds were introduced as part of a programme to improve organisational culture and began at a time when there was a commitment from executive level to look at a range of ways to improve staff experience. They were launched with the full and visible support of the Trust Board. The support that the Rounds received at all levels of the organisation and the way in which staff engaged with them suggested that there was a state of organisational readiness for new ways of talking about the impact of patient experience and just what it is like working in a healthcare organisation. This experience has been repeated again and again throughout the country in organisations which have started the Rounds, where they have been found to be highly appealing to staff and very well regarded and supported.

From the start, Royal Free Rounds have been very well attended and powerfully moving, and staff have participated fully, openly and honestly. The evaluation consistently shows that staff highly value them, and the way in which they have been responded to suggests that they meet an important need. Rounds are restorative and allow staff to constructively process difficult work experience, and gain reassurance and support. They equip staff with new ways of thinking about difficulty, reduce isolation, develop community, and role model coping with difficult emotions (Goodrich, 2011). Staff also report that the presence of the Rounds makes them feel proud to work for their organisation and reconnected to the values that first brought them into healthcare (Wren, 2012). Four and a half years later between 60 and 140 staff attend the Royal Free Rounds each month and the evaluation data shows that they are consistently highly rated and valued by staff.

How do Schwartz Rounds work?
There are a number of psychological mechanisms by which Schwartz rounds may be having an impact on staff experience and organisational culture. Research on supervision highlights the importance of reflective space in detoxifying the impact of emotional labour and providing space to think and remain effective while staying engaged with the emotional content of work. Role modelling is also an important part of a Schwartz intervention and there are many benefits for junior staff in witnessing senior staff role discussing their own human frailty and vulnerability. It is proposed that the following mechanisms are all at work in a Schwartz Round.

An opportunity to witness and a sense of community
The creation of resonance that occurs in Schwartz Rounds, that is developed through authentic storytelling, draws colleagues together and creates a sense of belonging. Witnessing increases the group’s appreciation of colleagues and the tough work they do. Both experiences create a sense of shared purpose and community.

A reduction in isolation
Healthcare workers have poorer mental health (Wren & Michie, 2003). Rounds help staff realise they are not alone, that feelings of...
Barbara Wren

incompetence and helplessness are common (and not necessarily related to actual performance), and that vulnerability is acceptable and can be acknowledged. This provides opportunities for profound relief.

A sense of coherence – an antidote to fragmentation
A sense of coherence (Antonovsky, 1987) helps people to stay well and even able to improve their health despite stressful experiences and situation. Regular attendance at Rounds may provide a sense of coherence through the following three elements of the Rounds experience:

(i) increasing comprehensibility of difficult work experience;
(ii) enhancing a sense of manageability; and
(iii) restoring meaningfulness.

An increase in compassion and in understanding the cost of doing healthcare work
Healthcare staff have been shown to be prone to self-criticism and perfectionism (Firth-Cozens, 2001) and the extent to which the process of attending Rounds may influence how staff relate to their own inner experience of doubt, self-criticism and anxiety is a fruitful one for exploration. Attendees at Schwartz Rounds are often very moved by the stories they hear their colleagues tell and the effort they have put into their work. Over time it is likely that this may increase their compassion for themselves as they see repeated acknowledgement in the Round of how tough healthcare work is and how vulnerable all staff can feel regardless of their role or their position in the organisation.

Coming to terms with ‘a failure to repair’
Rounds provide opportunities for attendees to consider their relationship to themselves, their chosen healthcare role and the feelings they have about the extent to which their organisation supports them in achieving the objectives of their role. Their motivation to take up this role will stem from conscious and unconscious personal and professional qualities and goals (Obholzer & Roberts, 1994). Achieving these complex goals is healing, enriching and rewarding. Being frustrated in

the achievement of these goals is stressful, damaging and can cause significant ill-health and relationship breakdown at work. Many Schwartz Rounds are concerned with cases where the healthcare professional was unable to ‘make it better’. Attendees are often moved by the openness with which panellists describe their sense of failure in relation to difficult cases, and over time Rounds discussions have tackled this difficult experience and supported and contributed to an understanding of staff who have expressed it.

Coming to terms with inadequate containment by healthcare organisations
Aside from the difficulties posed by the nature of the work, healthcare contexts are becoming tougher and tougher places to be. While agendas around staff well-being are espoused, healthcare work can expose staff to harm, and healthcare management style and constant change increasingly does. Rounds discussions often contain an underlying hope that somewhere there is a policy or strategy that will deal with this and that the organisation ‘must’ be able to protect them. Over time the Rounds help the community of staff to digest the fact that maybe there isn’t, it can’t, and to reflect on and appreciate how they are withstanding painful situations – and surviving in cases where it would be difficult to thrive.

A reconnection to the values that motivated the decision to enter health care
By reaching for the story of their experience of a patient, staff connect to the values that motivate them – this is an affirming experience that can help staff to withstand the ongoing worry that these values are being eroded in the current climate. Schwartz Rounds may help staff to hold fast to these values, especially when they can feel that they are not being held safely anywhere else.

A performance – a peek behind the curtain
Busy staff can experience a silo version of their organisation – feedback from the Rounds is that attenders really enjoy hearing about other people’s work and feelings. Everyone is curious about ‘other people’s business’. Rounds satisfy that curiosity. In this way, perhaps they
Schwartz Rounds: An intervention with potential

also have an opportunity to reduce misperceptions, clarify mysteries and bring darker areas out into the open – and in a legitimate way.

A consideration of the personal with the professional – Giving permission for stories of love, hate, hope, loss, satisfaction and regret

Schwartz rounds reveal the person in the professional role – the person who has been affected by their work – the person who made a connection to a patient to improve their experience. The experience of doing this and observing other people do it gives permission to reveal the deeply personal aspects of self that motivate staff in their work, and the relationships through which they carry out they work.

Levelling the playing field

Everyone in the hospital is invited to the Round – a recognition that all staff contribute to the community of this organisation – and are affected by its work. Rounds discussions create equality, model democracy, and allow staff to hear and understand the experiences of colleagues they would not normally have access to.

New consideration of how to negotiate relationships

Schwartz rounds are not just individual stories but involve a team ‘performing’ a story – the delicate negotiations and adjustments that are involved in the relationships that created that patient experience and also created that story, are both explicitly and implicitly exposed in the storytelling. Panellists sometimes describe their awareness of the impact they were having on each other and how it grew in preparing the Round. This creates opportunities in the Round to discuss how relationships are negotiated, to consider how different healthcare roles position people, to reflect on the difficulty of challenging colleagues, and to appreciate the pleasure of teamwork.

Conclusion

Telling stories, and building and maintaining attachments and connections help with the management of anxiety and meaning, as do staying connected to values and having space to make sense of and process experience. Schwartz Rounds create a space in which all these activities and processes are possible, while providing a cumulative and sustaining shared organisational experience that difficulty and complexity can be named and withstood, even if circumstances cannot be changed. In this way, healthcare organisations and their staff can be helped to be more reality based in their understanding of problems, and in the maintenance of compassion for patients, but maybe more importantly, for themselves.

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Introducing Schwartz Center Rounds into a Welsh NHS Health Board: Six months in – A reflection on the process and experience to date

Debbie Rees-Adams & Louise Hughes

Schwartz ROUNDS originated in the US and were initially piloted by the King’s Fund (renamed The Point of Care Foundation (PCF) in 2013) in the UK in 2009 following recognition of their positive outcomes for staff (which ultimately benefitted patients; Goodrich, 2011). The PCF has been involved in the development of Rounds in the UK since then. The main aim of Rounds is to provide a forum for staff from all disciplines to come together to explore and discuss the emotional challenges that their work can create for them. Schwartz Rounds adhere to a structured process which is described by the PCF (2013).

In our Welsh health board (Abertawe Bro Morgannwg University Health Board (ABM)), due to a growing awareness of the strains on NHS staff accompanied by some negative media coverage about poor patient experience, a direct request from the CEO was made to introduce Schwartz into the organisation. ABM provides a full range of services along a central section of the South Wales corridor for a population of 500,000 and employs 16,500 staff with a budget of £1.3 billion. The ABM is the first organisation to launch Schwartz Rounds in Wales.

A steering group was formed and a subsequent planning committee created from interested individuals, including representation from Senior Nursing, Nurse Education, Clinical Psychology, Chaplaincy, allied health professions, and medicine, including palliative and anaesthetic services. The authors of this article were chosen as the initial Round facilitators and duly attended PCF Schwartz training in London. Part of the Schwartz licence includes mentorship from a more established site, which in our case is from Cheltenham & Gloucester NHS Trust and for whose support we continue to be immensely grateful. Due to the size of our health board it was decided that we would start small by piloting the Rounds in one site.

We have run three Rounds to date, and in the style of Schwartz, would like to share some of the challenges in getting this off the ground, plus aspects which have been easier than anticipated – both of which may be of interest to other organisations contemplating introducing Schwartz.

As is often the case with new initiatives that are competing for time with everyone’s ‘day job’, attendance at the Planning Committee has varied and numbers have dwindled, meaning that the work has fallen onto the shoulders of a committed few, which is frustrating. The work involved is bigger than just attending the Round (particularly if in the Facilitator role) and includes needing to find potential panellists and helping them prepare their story. Other essential tasks include advertising the Round, organising the venue and refreshments, analysing the data from each Round and attending Planning Committee meetings. Of particular note is the flexibility required to meet with panel-
lists who may be limited in their availability. We have since asked managers from other disciplines (e.g. Estates and Housekeeping) to join the Planning Committee in order to increase the acceptability of Schwartz and diminish any assumption that it is only relevant to clinicians.

Despite only being three rounds in, we have already had to cope with late changes to the panel due to accident and have used members of the Planning Committee as last minute stand-ins (endorsing the PCF’s recommendation of having an emergency Round ‘up your sleeve’ for such eventualities). We have an ongoing practical issue with booking suitable venues, which has interrupted the flow of the Rounds and reflects the reality of Schwartz competing with other health board activities. We have had some perceived negative feedback about staff returning to their workplace seemingly distressed. We have taken this to mean that the Rounds have had their intended (i.e. emotional) effect and given reassurance that this is the organisation getting used to this as a longer-term intervention, that it is normal (and positive) for the emotional cogs to keep whirring after a Round, and that the Staff Counselling Service has not seen an increase in referrals because of Schwartz. Another challenge has been managing our own anxiety about what is largely an organic group process but one which feels very visible, both in the moment and as a new organisational intervention.

Aspects which have been easier than expected, include good attendance, and the audience quickly understanding the Rounds purpose and process. To date, we have had 54, 72 and 48 participants in our Rounds and have had little need to steer the discussion away from problem solving. The honesty of panellists in what they chose to share has been inspiring. Our third Round felt particularly cathartic as staff discussed the theme ‘A Patient I’ll Never Forget’ and both positive and negative feelings towards patients were exposed, such as working with patients we may dislike and how to care compassionately for them despite our human reaction. There is not space here to discuss the evaluation data in any detail but in the main it has been a positive experience for participants. The discussions at times have been uncomfortable (and we are under no illusions that certain topics will be more emotive), but in striving for transparency, this feels like a worthwhile undertaking.

We are pleased to have recently heard that funding has been granted to train a further four facilitators, which will enable us to expand the delivery of Rounds across four main sites within the AMB on a bi-monthly basis. We also intend to try to target those professional groups who have had the lowest attendances to date, whilst understanding that this is likely to be about release of staff, which is a competing issue.

In summary, the introduction of Schwartz has been both personally and organisationally anxiety provoking but it appears that the post-Francis climate is such that the time may never be better to shine a spotlight into deeper crevices of the health board, and our organisation currently appears willing to hear and listen.

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References
Military metaphors and mental health – Francis and psychiatric systems

Andrew Hider

‘The vast majority of front-line staff, who are consistently hard-working, conscientious and compassionate, have to understand that criticism of poor and unacceptable practice is not aimed at them but is part of a struggle to support everything they stand for.’ Robert Francis QC, The Francis Report: One year on – The response of acute trusts in England, February 2014, p.4

‘…what we need now, to fight the health problems that threaten the future of the NHS, is an army that’s fit to fight a war’. Christina Patterson, The Guardian, August 2014

The Francis Report (2013) has, in the space of a year, thoroughly penetrated the discourse and practice of healthcare in the UK, and the widespread reaction to it has to an extent reinvigorated an established narrative, which proceeds something like this: The NHS (and, arguably, all healthcare organisations) is characterised by the presence of two groups of people – the ‘hard working’ staff on the ‘front line’ of healthcare (often deified as ‘angels’), and the ‘managers and pen pushers’, ignorant and detached from the ‘front line’ and, worse, motivated by ‘savings’ and ‘targets’. Said managers, ignorant of reality ‘on the ground’, blindly drive services to ruin by prioritising processes over people, money over compassion. These two, mutually antagonistic, groups, fight as if at war. It is no surprise that healthcare attracts military metaphors – fear and emotional arousal accompany all human endeavours that place people at close proximity to death, suffering, and in the case of mental health, madness.

The reality, however, is more nuanced and in this paper it will be argued that there is a significant risk that simplistic accounts of the challenges facing mental health care in particular will eclipse the psychologically and behaviourally complex issues that obtain in the leadership, management and effective operation of such systems. It is argued that a psychological understanding of human systems needs to be prioritised rather than seen as an accessory to the solution. In particular, two relevant areas will be discussed. Firstly, deriving from the work of Zimbardo (2007), it will be argued that attention needs to be paid constantly to the psychological processes in psychiatric systems that, left unchecked, can allow poor and abusive practice to flourish. Secondly, deriving from the work of Bloom (2004), it will be argued that the unhelpful theoretical and epistemological battles in mental health care stem from a failure to recognise the psychological limitations we have that prevent us from truly understanding the clinical problems we try to ‘treat’.

The tactical reality of the battlefield

We think that we are nice, but often we are not

Psychologists need no introduction to the idea that good people can do bad things. The history of organised human society is one of violence and the forcible acquisition of property, as much as it is of altruism and shared effort. We know (Milgram, 1974) that social indicators of power exert significant effects on behaviour, to the extent that people are prepared to cause harm on the instruction of perceived powerful others. We also know that the desire to be accepted by a social group (and thus avoiding the depression inducing experience of social rejection) can influence behaviour (Asch, 1951). Recent findings in neuroscience have indicated that group influence even influences the perception of reality,
and that nonconformity induces a fear response marked by increased amygdala activation (Berns, 2005). Generally, people do what those in power tell them to do, and when one is established in a group, nonconformity is stressful and even emotionally painful.

Zimbardo, in *The Lucifer Effect* (2007) considers findings gained from observational accounts of organised inhumanity and experimental studies and refers to two principal factors – deindividuation and dehumanisation – that need to occur in social groups in order for them to act inhumanely (and can therefore be engineered and encouraged by those so inclined).

**Deindividuation**
This happens when systems are set up in such a way as to ensure that people easily see themselves as acting in the interests of a group with little cognitive control over their individual decisions. In common speech, the term ‘the madness of crowds’ describes this process. Zimbardo states that in order for this to happen one needs to encourage two distinct processes – reducing the cues of social accountability and reducing the concern for self-evaluation. Social accountability can be reduced by using any mechanism that protects individuals from the risk of social shame. This can be done either by allowing for anonymity (e.g. when rioters wear masks), or by associating a social cue (such as a uniform) with permission to use behaviours otherwise considered unacceptable. Concern for self-evaluation is inversely related to cognitive control, so any intervention that encourages actors to act under direct stimulus control, with little regard for past or future, can reduce it. Examples include the administration of alcohol or drugs, or exposure to highly arousing emotional experiences. Those militaries that have needed soldiers to commit crimes against humanity, such as the Nazi regime, used these principles very effectively to facilitate behaviours that people (military or otherwise) would not normally do.

**Dehumanisation**
With the possible exception of people with pronounced impairments in the ability to empathise, it is generally aversive for us to cause harm to other human beings, so leaders that wish to cause widespread suffering are required to consciously encourage the dehumanisation of victims. Dehumanisation occurs whenever someone is excluded from the ‘moral order of persons’ – from this point onwards excluded individuals tend to be seen as objects. Bandura et. al. (1996) refer to this ‘moral disengagement’ as a social psychological process characterised by four stages: Firstly, the redefinition of immoral behaviour as ‘honourable’ by citing compatibility with societal values or using sanitising language to describe the behaviour (e.g. ‘collateral damage’). Second, the diffusion or displacement of personal responsibility (e.g. giving away agency to authority). Third, changing the way we think about the actual harm we have done through cognitive distortion, minimisation and/or denials. And fourth, blaming the victim of our abuse by saying that they deserved it because they are not a ‘person’.

In systems, therefore, the simultaneous presence of de-individuated actors (who see themselves as essentially acting in the interests of a group) and a dehumanised outgroup, the interactions between which are overseen by a powerful hierarchy that encourages innate tendencies towards obedience and conformity, represents a potent recipe for harm. Zimbardo therefore argues that all social structures where one group intervenes onto another through the medium of power (particularly statutory power) should be ‘reverse engineered’ to prevent these natural tendencies from emerging in the system.

**The mental health system can traumatis e its staff and its users**
Nobody would wish to compare the mental health system to a battlefield, but for staff and service users it can sometimes feel like it. There is a reason that we refer to staff ‘on the
ground’ or ‘on the front line’. Many of the people we try to help have fallen victim to appalling abuse (Spataro et al., 2004). The ‘awfulness’ of the behaviour that can occur in many in-patient psychiatric units is testament to the awfulness of experience that often causes it. Sometimes it is easier to hold on to the idea that we are fighting blind disease, inflicted by solely nature, than enter into the reality that the past has been for many of the people we try to help (Winnicott, 1949). On occasion, the resort to technological explanations of distress can ‘turn off’ our emotional responses and protect us from engaging with suffering (Shapiro, 2008). Using a phrase such as ‘complex trauma with dissociation’ is easier than using language that accurately describes the events in the life of the person in front of us. We can be poor at holding both perspectives together, so we switch between technical medical or psychological explanations that can distance us and human interactions that can help alleviate suffering but can cause us significant vicarious distress. These ‘switching’ processes may be hard wired in humans (see below). None of us wishes to suffer, so we sometimes protect ourselves with technical language.

Thus, in mental health practice, the desire to avoid trauma can lead to accounts of people that can be lacking in humanity or, at worst, dehumanising. In particular, the noble aspiration of clinicians working in physical healthcare to ‘battle against disease’ can be problematic when applied to mental health, since if the ‘disease’ is identified as being the person, clinicians can end up engaged in fruitless battles with service users, all the while believing that they are in fact ‘treating’ them (witness the impact of poor clinical management of people diagnosed with personality disorder). Further, psychiatric in-patient environments, often characterised by high levels of emotional arousal, can encourage deindividuation, and occasionally the language we use can encourage this (e.g. physical intervention ‘response teams’ and protocols of various kinds). In such settings, where one group of human beings controls the movements, liberty and bodily integrity of another, the presence of factors that can encourage deindividuation, and language and technical accounts that can encourage dehumanisation, needs to be continually in the minds of clinical leaders and all those attempting to shape the behaviour of the system.

The Theatre of War

*Ideological battles encourage interdisciplinary warfighting in the clinical arena of a mental health system that lacks an adequate understanding of psychopathology*

The Francis report discusses profound issues with the culture of healthcare, with a principal focus on physical healthcare systems. In such systems, there is an acceptance that pathophysiology underpins physical diseases that are visible and testable. In mental health there is no such consensus, with the exception of some disorders in the areas of learning disability/autism services and dementia care. The aetiology of, and appropriate treatment for, the majority of problems described as mental illness or personality disorder remains far from settled, and is therefore a fertile ground for rhetoric and for political and clinical division. For the purposes of illustrating this final point in practice, the best course of action is to refer to recent highly public ‘battles’ between psychology and psychiatry, such as the Observer article of May 2013, with the headline ‘Psychiatrists under fire in mental health battle – British Psychological Society to declare war on rival profession’. These battle lines drawn within clinical teams are the death knell of effective multidisciplinary working.

As psychologists, we should constantly be reflecting on our own tendency towards falling victim to ingroup conformity, which for us, can on occasion be characterised by a tendency to ‘dehumanise’ outgroups who operate within a different epistemological framework (principally psychiatrists).
Human psychology may hinder the development of an adequate, integrated understanding of psychopathology

According to Bloom (2004), when it is faced with the task of constructing a causal explanation for an event, the mind has available two cognitive modules – the biological, reductive, ‘stuff’ explaining module, and the psychological, intentional/phenomenal, mind explaining one. In the case of ‘clinician minds’, both of these modules have access to information of both a considerable quantity and depth (e.g. the huge body of literature surrounding psychotic experience), thereby making it a cognitively effortful task to survey the field from even one of these standpoints. Further, it seems that the mind struggles with itself when trying to simultaneously process ‘mental’ and ‘material’ causal explanations of phenomena. It wants a single explanation when it sees things, and it may have what Bloom refers to as ‘inbuilt dualism’ between mind and body, person and system when approaching the world and how it operates.

Little surprise then that we see in practice the existence of two groups of practitioners, the minds of one of which have plum ped principally for the former and the minds of the others, the latter. Of course we need specialists whose job it is to explore one field in depth and understand each blade of grass within it. It is evolutionarily parsimonious for cooperative human societies to have developed in this way – just as cognitive modularisation and anatomical specialisation in the brain seems to be the most efficient way of processing information in individual terms, division of cognitive labour seems most efficient for societies – in other words, I do not care if my heart surgeon has read Jaspers (1913), but I’d like my psychiatrist to have done so, and I may not be concerned if my psychologist has an in depth technical knowledge of serotonin receptors, if that’s not what I need from her.

However, in clinical practice, as the cliché goes, if system as a whole adopts one mode of causal explanation, or even privileges one over the other, we end up with either a brainless or a mindless practice that does not benefit service users. How often is it that people are continued on medical treatment to little effect, despite severe negative side effects, without referral for psychological intervention. Or that psychologists resent medical oversight, even when the presentation suggests that it is needed? The argument here is that these practitioners may have rendered themselves psychologically unable to see things from a different perspective because of their sedim ented views, which in themselves are a reflection of the type of explanations their minds (and training) have caused them to favour, rather than, per se, ‘the truth’. Perhaps we need a new subdiscipline of ‘metapsychopathology’, focused on the psychological and neurocognitive factors that influence our attempts to understand our own psychological afflictions?

Unless we are careful, theoretical conflicts can be acted out in clinical practice, causing system-wide breakdowns in relationships between clinical leaders which foment ingroup/outgroup divisions within clinical teams, which in turn cause the real underlying problems of the system to remain inadequately addressed. While we remain far from a settled view regarding the aetiology and appropriate interventions for mental health problems, any professional group that pronounces with certainty on the causes of or solutions to complex clinical issues that we work with will, quite rightly, be regarded with suspicion and suspected of professionally motivated self promotion. Some of our recent pronouncements have made us look as if we are more concerned about being right what doesn’t work than about dedicating our efforts trying to make the system work as well as it could. This is unedifying and inappropriate for the highly educated, rigorously trained and clinically skilled profession that we are and wish to represent ourselves as.

So, if there is a ‘truth to tell’, it is that values-based principles should supersede all others in healthcare systems, regardless of the scientific positions of the clinicians working in them. We should be very careful not to make the assumption that the substitution of psychological formulation for diagnosis and psychologists for psychiatrists in mental health settings would automatically and radically change the behaviour of these systems,
absent consideration of the powerful social psychological processes operating in them. All professionals are capable of understanding these processes, and of taking steps to ensure that they do not go unfettered, causing poor (or abusive) service user experience. We should not make the changes in culture of care that we all know are required in the mental health system contingent upon us winning a theoretical war.

Conclusion – Towards disarmament

As psychologists we should be relentlessly reminding people of these inbuilt weaknesses in the mental health system, and working to ‘reverse engineer’ out these natural, if unfortunate, group behaviours. Certainly, retreat into oppositionality and militancy is unlikely to help – the mental health system is required. Some people require medication, and some people need to be admitted to hospital, and sometimes against their will. The challenge is to shape the system so that those characteristics it has with battle and division are minimised. Firstly, as Francis says, the principals and practices of clinical governance need to be adhered to continually by all services. However, there is a risk that governance becomes characterised by quantitative discourse alone. Tracking metrics is obviously important, but these need to be supplemented by active processes of ‘stakeholder governance’ – meaning high levels of service user power and external scrutiny, particularly over the use of preferred descriptive terms to describe psychiatric problems, in order to minimise any perceived message that once you become a mental health service user, you become a marginalised and powerless victim of a potentially hostile and powerful grouping (clinicians). In mental health, particularly forensic settings, this can be difficult – however, significant progress has been made in this area by bodies such as the National Recovery Outcomes Group in Secure Mental Health – a Department of Health funded body – and this should continue (see Callaghan, 2014). These processes, which bring service users alongside clinicians as powerful agents, reduce and minimise the risk of dehumanisation and also hold up service user bodies as groups to which clinicians are publically answerable, thus increasing their social accountability. Clinical Psychology should increasingly and explicitly adopt a shared leadership role here, influencing and supporting the multidisciplinary team from a position informed by scientific experimental psychology, particularly social psychology.

Secondly, while Francis talks about culture of care and the importance of compassion, this paper suggests that both the processes of the mental health system and the nature of the problems that it treats can induce psychological states that reduce compassion, either by encouraging an overemphasis on technological reductionism and/or by exposing staff and service users to the kind of emotional arousal and group dynamic that encourages deindividuation. As such, exhortations to compassion through the media of leaflet campaigns and lectures are unlikely to work alone. More likely to be effective are constant and strategically visible reinforcement of ‘pro-cultural’ behaviours such as basic kindness by staff at all levels, high quality clinical supervision, and conscious reward and modelling of such behaviours by clinical leaders, particularly those nursing staff at ward level. As such, supervision and support of clinical leaders (as opposed to targeting and blaming) is critical. Clinical psychologists are well positioned to support all these interventions, should prioritise them, and in many areas are doing so. Clinical psychologists, it goes without saying, should physically be on wards as much as possible, working alongside nursing colleagues to support this modelling.

Thirdly, the mental health professions need to engage in honest debate about their ideological and theoretical struggles and do so in an adult and psychologically informed way. Simplistic accounts of ‘the medical model’ or ‘the psychological model’ are unhelpful and at worst can encourage sedimentation of inflexible positions by psychologists and psychiatrists...
who feel attacked because of their views and naturally retreat into defence, thus reinforcing ‘natural dualism’ and preventing the further development of an integrated understanding of mental distress. For clinical psychology this is particularly important because of our lack of relative power and therefore vulnerability to marginalisation if we are perceived as predominantly obstructive, oppositional, and prioritising theoretical concerns over the practical operational demands of running hospitals and clinical services. At least, a settled view on the general principles of good mental healthcare, that can be pragmatically applied to its governance, independent of privileged adherence to epistemological models, is urgently required if we are to free ourselves from war-like engagement with service users and each other, and focus our efforts on remediating those aspects of the mental health system that we should all agree need to change. In other words, we, all of us, psychologist or not, need to be clear about what we stand for, so that we can struggle for it.

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THE EVIDENCE is convincing that work related stress is extremely damaging, not just to the staff that experience it, but also to their relationships with patients and to the experiences patients have of the care provided by the NHS (West et al., 2011). There is also a substantial literature demonstrating that service redesigns and other changes in the NHS place staff at particular risk of stress and disengagement. NHS changes often leave staff with a lowered sense of personal effectiveness, more prone to emotional exhaustion, more likely to make errors (which are again a source of more stress), more likely to be self-critical, and more likely to lack of compassion towards self and patients (Gilbert, 2009). So why are we in the NHS constantly involved in change? Let’s consider a number of hypotheses...

1. The public are not happy with the NHS
There is very little evidence that the public are dissatisfied with NHS. The British Social Attitudes Survey published by the King’s Fund found that, in 2012, 61 per cent of people were satisfied with the NHS, compared with 58 per cent in 2011 and 70 per cent in 2010 (King’s Fund, 2012a). The World Health Organisation published its rankings of 190 of the world’s healthcare systems in 2000 and ranked the UK at 15th in Europe (World Health Organization, 2000). Many people feel that universal free healthcare at the point of delivery is an extraordinary achievement. In fact, we are so proud of our NHS that it has come to represent something about us as a nation – who we are – and something we are proud to showcase at our Olympic opening ceremony.

2. Universal healthcare is unworkable
Universal healthcare is not, of course, a purely British phenomenon. Outside the USA virtually every developed country provides comprehensive universal healthcare so there is no evidence that it is unworkable. In fact, some European countries provide greater coverage than the NHS; for example, including optician and dentistry services and long-term nursing care.

The UK has a very high level of public funding (World Health Organization, 2000), but there are many other systems paid for out of taxation (like ours), whilst others are funded through compulsory insurance, or a mixture of both. In the UK, the only additional payment people are asked to make from their own pockets is the prescription fee (currently £8.05), while most other countries require a contribution towards the cost of care. In some countries the state is the main provider of care and in other countries private and voluntary agencies provide the bulk of services.

The NHS ‘brand’ makes it easy for us to attach to, and become sentimental about, our healthcare. Perhaps this is why the NHS is so embedded in our sense of identity. Many healthcare professionals (such as psychologists, doctors and nurses) are trained ‘in’ the NHS and identify themselves with it. The tasks of the NHS (saving lives, relieving suffering etc.) are heroic and often invoke gratitude and affection from patients, and the single brand encourages focus and loyalty. But of course the NHS is not one thing; some aspects of healthcare are more effective and efficient, than others – some are frankly outdated and potentially unsafe.

There is no evidence that universal healthcare is unworkable, but how should we pay attention to and address those aspects of the
Staff stress, change and the NHS

NHS which are not working well whilst retaining the bits that are? This is the wicked problem which is driving us to make changes in the NHS.

3. The NHS is inefficient, inaccessible and poor quality

There is good evidence that the NHS is very efficient. A study by Davis et al. (2014) for the Commonwealth Fund compared the health systems in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the UK and the US. The US was consistently the most expensive health care system and amongst the worst in terms of access, efficiency and equity; however, the UK healthcare system was consistently ranked first on all these aspects. Of course, it all depends on how quality, efficiency, equity and accessibility are measured. In the UK, we have fewer doctors per capita (Ingleby et al., 2012).

Before we conclude that if the NHS ranks first amongst all these countries change (or at least the current pace of change) is not necessary, it is worth noting that the same study Davis et al. (2014) found that the UK was poor (relative to other countries) in terms of health outcomes as measured by ‘mortality amenable to medical care, infant mortality, and healthy life expectancy at age 60’.

4. The NHS is unaffordable

It is a universal problem not confined to the UK that healthcare costs are growing exponentially. It is not simply a matter of fact that we are living longer and receiving healthcare for longer (and more of us are doing that), but also that we expect more from our healthcare providers in terms of what constitutes ‘good health’. It is now possible to treat conditions which even a decade ago we could not and we all expect to benefit from these costly new treatments, techniques and other developments (which continue to emerge). In other words, the NHS is extremely successful, and as a result extremely expensive.

Clearly there must be a limit to these escalating costs or the NHS will be unaffordable, but the question really is ‘what are we, as a society, prepared to spend on our health?’ There is also a question about who decides what the priorities are. Most people consider their health and that of their loved ones a priority; if that is the case then the healthcare spend needs to cover all the costs that people with sufficient resources would choose to spend on their health – and that is ‘a great deal’. And costs are rising. If the public does not accept these rising costs, then we will need to decide which costs we are willing to bear and which we are not – and we currently have no equitable mechanism for doing this.

A recent BBC news report highlights the point. On 10 August, Nick Triggle reported that a pioneering new breast cancer treatment will not be routinely available in England and Wales. The drug – Kadcyla – adds six months of life on average to women dying with an aggressive form of breast cancer; however, it costs £90,000 per patient. Whether this is a price worth paying (considering what £90,000 can buy) may depend on whether you or your loved one has this form of cancer. This is difficult enough but most cost decisions are not so straightforward.

5. Decisions about healthcare are influenced by power

If decisions about who should and who should not receive healthcare are not carefully reviewed against principles of equity then the people who lose out are those who do not have a strong voice or for whom treatments are complex, expensive and relatively new. The absence of access by people with mental health problems to psychological therapies might be a case in point. Decisions to fund these therapies have generally been left to local commissioners to decide whether or not to fund; however, setting national targets (e.g. for treatments or process standards) and commissioning principles can also skew services, exacerbate stress and curtail autonomy to provide the services local people need (King’s Fund, 2012b).

Involving clinicians in the changes required in the NHS has come to be understood as a key mechanism of change. Clini-
cians are the experts in health care and are assumed to be motivated primarily by the good of the patients. Of course the gremlin of personal profiteering is a concern and the arguments about privatisation in the NHS have partly consisted of concerns that clinicians’ primary motivation might become one of greed rather than altruistic concern for others.

Furthermore, supporting clinician autonomy does not always result in the best evidenced decisions and leads to high levels of clinical variation. A well-known US study showed that, in such circumstances, patients only received half the interventions they should have (McGlynn et al., 2003). Clinical variation is one of the biggest causes of waste in the NHS, but setting standards is also fraught with problems as lack of clinical autonomy exacerbates staff stress.

6. The NHS does not achieve the best health outcomes
We have seen evidence (Davis et al., 2014) that health outcomes in the UK are not good compared to other health systems. One driver for all the change in the NHS must be to achieve better outcomes – and there is evidence that this can be done cost-effectively. Derek Wanless in 2002 identified the importance of individuals taking more responsibility for their health; however, the challenge of persuading people of lifestyle changes has not been easy. Campaigns to improve the nation’s diet, reduce obesity, increase exercise, stop smoking, etc. have had limited success and health inequalities are increasing with a widening health gap between rich and poor (Pickett & Wilkinson, 2013).

Despite almost unanimous agreement about these health challenges there seem to be no easy answers. Attempts to link health responsibility with access to healthcare have been controversial; for example, some Trusts refused non-emergency treatments to patients until they changed their eating and smoking habits (Smith, 2010). More challenging might be to embrace the robust evidence that equality is better for everyone, and not just be poor (Wilkinson & Pickett, 2010), but so far the healthcare design which will achieve this has not been realised!

Nigel Crisp (2010) in Turning the World Upside Down provided numerous examples from less wealthy countries which could (and on occasion have) brought significant cost savings and health gains in the UK. However, to truly realise these benefits the professional power bases (most notably medicine, but we cannot ignore the implications for psychology) would need to be in support.

7. Is there an argument raging about the ideology underpinning the NHS?
There have been many arguments about the Health and Social Care Act. In NHS SOS (Tallis & Davis, 2013), several major critics of the bill have argued that the recent changes in the NHS represent a battle of ideologies and that the bill is fuelled by a will to privatise the NHS and turn health care into a profit-making industry. However, this view is far from universally supported and Roger Taylor (2013), for example, argues forcefully for the alternative position that there is an ‘alarming degree of consensus across the political spectrum’ about the challenges facing the NHS and the complexity of the possible solutions.

8. We lack the information we need to get the NHS right
Healthcare is a huge undertaking. Measuring health outcomes (e.g. hospital deaths) is a good way of understanding the impact of health care provision; however, outcomes are hard to measure and even harder to manage. Often we simply do not know which factors contribute to particular outcomes. For example, when Mid Staffordshire hospital was trying to understand their elevated death rates a group of clinicians reviewed patient case notes and found that 34 out of 35 deaths were entirely ‘predictable’. The scale of the information challenge is well described by Roger Taylor (2013) and his conclusion that the NHS will continue to change, as we clumsily iterate towards the kind of healthcare we believe best meets our needs, is convincing.

Conclusion
The NHS is a national institution and one with which we are generally happy. It is efficient, accessible, and provides high quality
care; however, our health outcomes do not compare favourably with other similar countries. Furthermore, healthcare costs are rising exponentially and we have no clear mechanism for deciding what should be funded and what should not – so it is likely that we will get things wrong and need to change them. There are all sorts of problems plaguing our ability to design the best healthcare. In mental health we have seen years of low investment (relative to physical health) and the recent acknowledgement that we need ‘parity of esteem’ is welcome but inevitably will require more changes – and of course there are many other health inequalities which need to be addressed.

It is tempting to think that leaving the NHS in the hands of clinicians would solve our problems, and of course it is important that clinicians are entrusted and enabled to respond to the needs of the patients they work with. However, high levels of clinical autonomy are associated with high levels of clinical variation and this leads to both wasteful services and patients not receiving the best evidenced interventions.

The Wanless Report (2002) was crucial in terms of recognising the importance of patients being in the driving seat of health care provision and taking responsibility for their health. Unfortunately, progress has been slow and the need for more change is widely recognised. Therefore it seems that further change in the NHS is needed, but this will inevitably lead to high levels of staff stress, and the risks for patient care (and to staff themselves) are well known. We need to develop mechanisms to build staff resilience and enable people to remain emotionally engaged and behaviourally flexible enough to function effectively in the context of change.

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References


I HAVE BEEN actively involved in national mental health policy since 2005; less so since taking on further responsibility within my NHS role in 2012. I am grateful, if at the same time a bit regretful, for having taken so long to have been persuaded to share my views on how the Division of Clinical Psychology and the British Psychological Society (BPS) as a whole can increase its political and professional influence in national policy. I have little to offer beyond my on-the-ground experience, largely following trial-and-error and gut instinct. I very much hope that sharing the following anecdotes, and derived principles, will help others to take our mission forward.

I was, at the beginning, nudged forward into policy arenas by others (willingly, looking for a way to contribute politically as well as clinically) – by the end, I was undertaking a fair bit of the nudging of others, overtly and at times decidedly behind the scenes. If not clearly implicit below, I should here make it explicit that especially three individuals within the DCP Executive at the time supported and joined in with my efforts from start to finish: Peter Kinderman, Jenny Taylor and David Murphy – I owe each a debt of gratitude for their collaboration.

Psychologist, know thyself

I have been described variously, in leadership terminology, as a ‘fox’, a ‘stalking horse’ and ‘a Marine commando operating on his own recognizance’ (the latter by someone higher up in the BPS who was both impressed by and annoyed with me at the time). I am not sure about what any of these terms really mean, even after googling them; I came to learn that I preferred to stay backstage, that I am better at writing than speaking, that I am camera-and tape recorder-shy and that I tend to wait for ‘greatness’ (such as it might be) to be thrust upon me rather than seek it (certainly not born to it!). Once you accept who you are and how you operate in policy, you can become quite effective by playing to your strengths rather than trying to step into the big shoes of predecessors.

Keep it clear and simple

I have followed, in particular, one key objective: to work toward parity in the delivery of evidence-based treatments between medicines and psychological interventions, and thus ensure that service users, as elsewhere in the NHS, can access the full range of effective treatments which, in combination, produce the best outcomes. I began my policy career representing the British Psychological Society within the development of Accreditation for In-patient Mental Health Services (AIMS), commenced within the Royal College of Psychiatrists. Citing numerous studies by Mind, Rethink and other service user representative organisations alongside NICE guidance (see below), the DCP’s efforts within AIMS over several years has produced mandatory minimum standards of training for and provision of evidence-based psychological interventions on all AIMS-accredited wards. As a result, hundreds of psychologist/psychological therapist posts serving thousands of patients have come into being on AIMS-accredited wards.

Triangulate where possible

Triangulating between commissioning, regulation and/or national guidance, professional standards and unmet service user needs has proved an effective strategy time and again – one in which initial detractors can be drawn into an aligned position, removing obstacles to progress.
During the same period as my initial AIMS work, I successfully lobbied the National Collaborating Centre for Mental Health within NICE to ensure that guidance was clarified with respect to commencing recommended psychological therapies in the acute phase of illness. Various heads of psychology around the country had targeted clinical resources mainly (at times exclusively) toward community patients, as it was argued that in-patient work was less important given the time frame recommended by NICE could not be accommodated by the typical in-patient length of stay. As a result of this intervention, NICE guidance updates for schizophrenia and depression, with more to follow, have given new emphasis to the goal of commencing psychological treatment for patients in acute distress, a further lever of assurance that psychology will increasingly be there for those most at risk and in need. I then worked to ensure that the DCP set out its own guidance, directly to heads of psychology, instructing them to adhere to the revised NICE recommendations and facilitate commissioning of acute in-patient and crisis psychology.

Lastly, I have worked directly as a DCP/BPS representative with the Care Quality Commission (CQC) over many years and over several iterations of expert reference groups and regulator-professional interface working parties. As virtually a last vestige of my policy role, I remain closely involved in the CQC’s evolution in regulating mental health services, taking part as the BPS representative in its Mental Health Expert Reference Group by invitation. I am excited to see that my efforts, alongside representatives of the National Collaborating Centre for Mental Health, the Department of Health and service user groups, are now promised to result in CQC regulation of access to psychological interventions across services, starting with those which carry the most risk, including acute.

When I began, with a vision in mind as a potential outcome, very little attention was paid to the psychological needs of the acutely distressed. Now the shared concerns of service users, professional groups and regulators are marrying up to re-shaped national guidance on evidence-based practice and enhanced standards of access. The under-served position of the acutely distressed is difficult for commissioners to ignore, and clear to see how progress in increasing access to evidence-based psychological therapies must go forward. It is also clear to all involved that leadership, training, supervision, and provision for the most complex and risky presentations would predominantly fit the skill set of clinical psychologists.

Do not take your placards and go home – find compromise

My policy work began to take off when I was invited, by the BPS’ Division of Clinical Psychology, into internal and external debates around proposals for an expansion of professions eligible for statutory roles under what was to become the new Mental Health Act (2007). I was asked to take part in a debate in the House of Lords, and ultimately wrote sections of implementation guidance published by the government on role implementation. The direction of travel in the debates did not proceed the way I had initially hoped, and I was tempted to walk away. But I was invited to stay on within the DCP’s Mental Health Act Working Party as pretty much a ‘critical friend’, ultimately influencing the government’s implementation guidance to mitigate against risks ultimately agreed but initially unforeseen by working party members who had, just months previously, been adversaries. What I learned here, thankfully early on, is that if a policy initiative produces discomfort or discord, abandonment will produce a less well-resolved result – we owe a duty of care to service users and to our profession to stay involved and hammer out the best compromise solution possible. We must keep true to our ideals, but at the same time, grasp the realpolitik of the day.

Seek information, and ask the right questions at the right time

Initially, I felt I needed to demonstrate that I knew enough about what others, more
established and experienced, were talking about – especially in the higher echelons of power. I never really changed that perspective, but I became increasingly adept at asking the right (kind and trustworthy) people for further details, so that I could actually feel that I knew enough.

I also, initially, felt I must always ask a question, or raise a point, in policy forums, at least one question and more if I could come up with them. I later came to feel more relaxed about this; we need to be visible, and active, but not necessarily always front-row with our hand waving in the air. The right question or point at the right time will have the most resonance.

Get your own house in order
After assuming the elected role of DCP Policy Director, in 2009, I helped to lead the We Need to Talk (WNTT) campaign to retain central Improving Access to Psychological Therapy (IAPT) funding and to extend access of evidence-based psychological interventions to all who would benefit; the leaders of all three main political parties signed up to a promise to achieve this during what is now the current parliamentary administration. The campaign was instrumental in not only maintaining funding for IAPT for primary care, but also for creating IAPT programmes for severe mental illness, older adults, children and young people, and long term needs/medically unexplained symptoms.

A significant part of keeping the WNTT coalition together was the need, immediately apparent at the outset, to decide whether to back a position of increasing access of all evidence-based, NICE-recommended psychological therapies, or as others advocated, increasing access to all psychological therapies, regardless of status with NICE. It was difficult to reconcile, as the former would invariably lead to the decommissioning of the latter. My pitch, that we need to consider public money spend on public health services, that every other component part of the NHS broadly implemented NICE guidance where this had yet to be accomplished in mental health services and we could not stand by to allow this to continue, proved incomplete. Resistance remained within the DCP and within the New Savoy Partnership alike – expanding choice to include orientations yet to be recommended by NICE was also essential, but how to represent what appeared to be polar opposite positions?

I proposed that we prioritise increased access to NICE-recommended psychological interventions, while also: (i) arranging secondary access to other valued interventions when evidence-based approaches had not proved successful; and (ii) campaigning for set-aside research funding to promote the systematic evaluation of therapies yet to be recommended by NICE for lack of RCT-level evidence. This stance was helpful in bringing about consensus and consequent forward movement.

Brinksmanship–as a last resort
Without going into detail, the DCP faced a few situations at the highest level of policy formation where it appeared that certain vested interests were set to exclude the BPS, or minimise our role and function within the group, or to fold the BPS into a superordinate grouping consisting of a broad umbrella of psychological therapy representative groups. It was vital to be in a position to present the legitimacy of the DCP/BPS to lead the field, often drawing on leadership roles held within the NHS and on our orientation toward evidence-based practice over and above particular modes of therapy. At difficult times, brinksmanship came into the negotiating process, sometimes using the bulldog-retriever approach where someone in higher authority, typically the Chair of the DCP Executive, would mandate inclusion while threatening public withdrawal of DCP/BPS endorsement (the bulldog) and then typically the Policy Director (the retriever, me at the time) working toward a reconciled, and included, position. Uncomfortable, but necessary, and effective.
Be helpful beyond your brief in putting service users first

I found being helpful wherever feasible, not just where directly advantageous, repeatedly gained ground. When the Royal College of GPs opted to retire the unmanageable Quality Outcome Framework (QOF) indicators for depression, I was asked by the National Clinical Director for Mental Health to help. I instigated and led a campaign with policy colleagues across mental health to persuade the Royal College of GPs to revise rather than retire the standards. After very tactful negotiations, the QOF standards were revised and retained and QOF-led referrals from primary care to IAPT were safeguarded. This was good for psychology and for the DCP, but better still for service users and the field at large. Leading on this paid dividends for quite a while afterwards in the form of greater proactive inclusion in national policy formation.

Keep your friends close, and make friends with your would-be rivals

Following Peter Kinderman’s instigation, I helped to co-found the Inter-professional Collaborative for Mental Health, comprised of policy leads for clinical psychology, psychiatry, nursing, social work and occupational therapy working together as a multidisciplinary team on mutual concerns in the field. I also, alongside particularly David Murphy, worked to negotiate a collaborative approach with the New Savoy Partnership. It would be clear to each of these organisations as it should be to us that conflict among component parts of the mental health field has re-directed political attention (as acknowledged by one Minister for Mental Health and Social Care, who described the rancour over the last draft Mental Health Bill as ‘a nightmare’) and research funds (a very senior figure in health research noted that ‘no one fights in the cancer field; cancer gets the research funds’). There is more that binds us than divides us. I did all I could to allow peace to break out; I hope this can continue.

Volunteer, delegate and develop emerging talent

I secured an invitation for BPS representation on the Joint Commissioning Panel for Mental Health, a joint venture led by the Royal College of Psychiatrists (RCPsych) and the Royal College of GPs. It felt vital to contribute as far shoulder-to-shoulder as possible with psychiatry in guiding commissioners toward exemplar service models delivering a balance between evidence-based medicine and psychological interventions; I was determined to ensure that a specialist psychologist was assigned to each JCP-MH commissioning guidance working party and took a co-lead on the acute care and the community mental health guidance. Via the DCP leadership, I got in touch with each relevant Faculty and persuaded national committees to find a way to put someone with reasonably deep experience and expertise forward for service area-specific guidance – we placed someone exceptional in each descriptor group.

We all know that most of the work coming out of the DCP is taken forward by volunteers; if each of us from mid-career onward (while bringing along promising junior colleagues) can place themselves within a national workstream, not only do we achieve a great deal together but each clinician and their sponsoring Trust gains advantage from direct and timely access to policy formation.

Be nice, and be discreet when needing to be constructive

This really does not hurt, and helps considerably. Copy in loads of colleagues when delivering kudos; save the brickbats for face-to-face or at least telephone (not teleconference) contact. This goes for back-filled posts as well, but especially for voluntary efforts, especially when you want a return, if sometimes slightly revised, performance.

The policy initiatives I co-led or led were many and varied, ranging from commissioning, to Payment-by-Results, to regulation. I accepted invitations to present on a wide range of policy topics to a diverse policy audience, including the RCPsych’s annual conference, the New Savoy Partnership, committees led by the National Director for Mental Health and to many DCP strategy groups and faculties.
Communicate to members and to the public
This is something at which I did not excel, relying on others to blow our collective trumpet, which consequently did not often sound, and I am afraid a lot of what at the time scored points for us did not register on the scoreboard. Sometimes emergent success seemed too fragile to publicly reveal; too sensitive to be seen to crow about – sometimes I just felt more comfortable chalking it up and moving on to the next project, personally feeling more relaxed when out of the spotlight. I did not feel drawn to the media spotlight, especially. Where valuable work was successfully telegraphed, a consistent media/communications function mirrored policy interventions as separate, complementary roles; this is possible within DCP/BPS structures and I should have, in hindsight, valued this more.

I have, at least, communicated subsequently, with this tardy briefing! I hope, as above, that these reflections will be useful to others picking up the baton (I have not ruled out re-entering the race, but perhaps more on that another time…).

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IMPLEMENTING NHS CULTURE CHANGE: CONTRIBUTIONS FROM OCCUPATIONAL PSYCHOLOGY

Grace Everest, Joanna Fitzgerald & Louisa Tate

THE OCCUPATIONAL PSYCHOLOGY in Public Policy (OIPP) working group, part of the Division of Occupational Psychology is releasing a report this November titled, Implementing NHS Culture Change: Contributions from occupational psychology. The report aims to address the issue of how to implement the recommendations for culture change within NHS hospital trusts, as detailed within the Francis report and subsequent Berwick review.

OIPP’s report aims not to rehearse the valuable analyses that have been produced by a wide range of organisations in response to the Francis report, including health think tanks and the Health Select Committee, but to shed light on the utility of employing psychological evidence and expertise when embarking on the practical implementation of NHS culture change. Indeed, the need to move the discussion on at this stage from what needs to be done and on to ‘how’ to make NHS culture change a reality has been widely recognised in policy circles, including by The King’s Fund, which has reflected that, ‘...the real challenge is not in the diagnosis and prescription for the problem, it is ensuring that the remedy is administered effectively’. Likewise, the Royal College of Nursing remarked in its response to the Francis report that, ‘Robert Francis has set out a clear direction for the future of the health service; the onus is now on all of us to make sure we follow it.’

OIPP aims to contribute to these objectives by providing an occupational psychology perspective on the practical steps required to deliver organisational culture change within the NHS. The Berwick review highlighted the fact that ‘good people can fail to meet patients’ needs when their working conditions do not provide them with the conditions for success’, and argued that in pursuing a positive NHS culture, a ‘measured and balanced response, anchored in science and evidence, serves the nation well’. Occupational Psychology as a discipline is concerned with the performance of people at work and with how individuals, small groups and organisations behave and function. Its aim is to increase the effectiveness of the organisation and improve the job satisfaction of individuals. Therefore, occupational psychologists, as scientists of people at work and with practical experience of intervening in a range of organisational contexts, can offer NHS hospital trusts valuable insights into how the working conditions for success can be created and sustained.

Whilst the Francis report makes a total of 290 recommendations, OIPP has chosen to focus its report on a smaller number of core recommendations for NHS culture change which relate closely to some of the key knowledge areas of occupational psychology. These include ensuring that staff are engaged and supported to deliver compassionate care, creating stronger healthcare leaders and developing a climate of transparency, openness and candour. It has also been recognised by the Berwick review that a new organisational culture, one devoted to continual learning, must take root in order for patient experience to be improved. In line with these recommendations, the report is divided into three sections. Section one includes overview chapters on the key points to consider when undertaking a journey of organisational culture change; section two
explores the role of leaders in implementing culture change at a broad level and in enabling staff well-being; and the final section details the steps required to recruit the best staff and create working conditions that are conducive to the delivery of compassionate, safe care. In line with OPIPP’s aim to ensure that the evidence base of psychology is utilised during the public policy process, all of the report’s chapters feature case studies with clear ‘how to’ recommendations for policymakers and healthcare leaders to adopt, and which are also likely to be of relevance to other public service organisations.

An overarching theme, tying together the different chapter recommendations, concerns the importance of moving beyond command and control hierarchies and towards collective and participative leadership in the NHS, with an emphasis on the need for hospital trusts to develop more collaborative relationships between healthcare leaders and their staff. For example, Michal Tombs-Katz’s chapter on ‘Fostering a continuous learning culture in the NHS: The role of leadership’, stresses that senior leaders at all levels in the NHS should approach a continuous learning culture as not only a function of top-down strategy and formal training, but as the product of a work environment built on empowerment, open communication and bottom-up processes of co-production. Her discussion of effective electronic workbook development advocates that hospital teams should be ‘empowered to express their own way of doing things and to influence practice’, with the autonomy to customise their own learning workbooks. Beverley Alimo-Metcalfe and Juliette Alban-Metcalfe’s chapter on ‘Leading and managing high performing teams’ also recommends that the NHS embrace a more contemporary understanding of leadership as a shared social activity that ‘emerges through collaborative relationships’. They encourage hospital leaders to look upon their role not as leaders inputting into their team, but as the outcome of team members working together.

The chapter contributed by Chris Clegg et al., which is focused on ‘Work design for compassionate care and patient safety’ likewise warns against top-down inspections and audits after the event. Instead, Clegg et al. detail a number of recommendations to ensure that staff are empowered and trusted to act when things go wrong. These include ensuring that ward layouts support daily care roles by allowing a clear ‘line of sight’ to patients to enable effective monitoring and response, and developing a national framework for change which is agreed upon at the local ward level.

Rosalind Searle and Alison Legood’s chapter on ‘Improving trust board effectiveness and governance’ similarly taps into the theme of collective leadership, advising hospital boards to diversify and become more inclusive by ensuring greater involvement of clinicians and women. Their chapter emphasises the need for boards to improve the behavioural style of their members so that they become more ‘developmental’, sharing knowledge, being open and responsive to error detection, and modelling the required behaviours of staff lower down in the hospital.

In addition to this theme of collective leadership, many of the report’s chapters also indicate the value of drawing upon a synthesis of psychological evidence and expertise when seeking to implement culture change. Barbara Wren’s chapter, in particular, on ‘Managing staff experience to improve organisational culture’ describes interventions which draw on occupational, health and clinical psychology theoretical frameworks, and considers the conscious and unconscious processes that influence the current culture in healthcare. In her article she proposes that implementing change requires taking a systemic perspective when designing interventions at role, team and organisational level. She discusses the vital role for psychology in helping organisations understand and manage anxiety in order to choose appropriate and well positioned intervention strategies, and the benefit of drawing on a range of psychological frameworks to help organisations manage meaning, create safety and address complexity in a reality based way. Joanna Fitzgerald-...
ald’s chapter too employs a model of psychological imperatives in the workplace to describe how ‘Cultures of transparency and openness’ (CTO) can be created, arguing that the extent to which a CTO can be built and sustained is directly linked to the degree of ‘psychological safety’ in any system.

Thus, OPIPP’s report contains a diverse range of chapters, each exploring different aspects of organisational culture – from the boards to the wards of hospitals – which must be addressed simultaneously in order to create an NHS that is patient-centred and safety focused. The chapters are united in their aim of employing occupational psychology evidence and expertise to understand these processes of organisational culture change and provide practical suggestions for those who are responsible for instigating transformation.

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Implementing NHS Culture Change: Contributions from occupational psychology

Full list of chapters:
- Fiona Patterson, Lara Zibarras & Helena Murray: Values-based Recruitment for Patient-Centred Care
- Barbara Wren: Managing Staff Experience to Improve Organisational Culture
- Chris Clegg, Lucy Bolton, Ryan Offutt and Matthew Davis: Work Design for Compassionate Care
- Rosalind Searle, Alison Legood & Kevin Teoh: Trust Boards and Governance: Composition and Behavioural Styles
- Michal Tombs-Katz: Fostering a Continuous Learning Culture in the NHS: The role of leadership
- Joanna Wilde: Building Cultures of Openness and Transparency
- Michael Wellin: Managing Culture Change in the NHS: An Overview

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Compassion, organisations and leadership

Stuart Whomsley

Caring for others in an organised way requires practitioners of all disciplines to be compassionate, organisations to be efficient, and leaders to be both. This is complex and many thousands of words have been written about the issues connected to these requirements, particularly over the last two years. The following is an attempt to distil some of the main issues into a summary of psychologically relevant points.

Compassion: If you stand in the light you cast a shadow

1. What is compassion?

IF WE ARE trying to teach compassion we must first truly understand what compassion is. Compassion means to suffer with others and have a desire to alleviate that suffering. Compassion has been defined by Gilbert (2005) as follows:

Compassion (which is an element of loving-kindness) involves being open to the suffering of self and others, in a non-defensive and non-judgmental way. Compassion also involves a desire to relieve suffering, cognitions related to understanding the causes of suffering, and behaviours-acting with compassion. Hence, it is from a combination of motives, emotions, thoughts and behaviours that compassion emerges.

From this understanding of compassion Gilbert has developed a therapeutic approach, compassion-focused therapy. In addition, Ballatt and Campling (2011) have put forward their model for ‘intelligent kindness’ in healthcare on the basis that intellectually and emotionally we recognise others as our kin, and recognise and wish to alleviate their suffering.

If in your work with a person who is suffering you are left only feeling good about yourself because of your good deeds and you are not hurt a little, maybe you were not being compassionate at all. The ability of people to suffer with another or recognise them as their kin will vary both for an individual over time as their circumstances change, and between people. If we want compassionate services we need to select people who can suffer with others, recognise their shared humanity, and create and maintain organisations that enable them to do so and act to alleviate suffering.

2. Everything has its shadow

According to the work of Jung (1959) everyone, every team and every organisation has a shadow, containing aspects that it consciously does not want to identify with. Every word used to express a quality has its antonym. For compassionate the antonyms are: hardhearted, unfeeling, indifferent and merciless. Individuals, teams and organisations who aim to be compassionate may hold these antonym qualities in their shadows. For example, in healthcare settings another person’s vulnerability may be ignored, or treated with indifferent, or in hardhearted way. This may be the consequence of the schemas the healthcare professional developed in childhood modelled by their parents’ behaviours to internalise the belief that to show vulnerability is wrong. The professional’s career choice to join a caring profession may still contain this shadow.

3. A normal distribution?

Compassion can be understood as both a trait and a state that offers an evolutionary advantage (Goetz et al., 2010). But as a trait, is it normally distributed in the general population? And if so, are members of the caring professions at the more compassionate end of the distribution? As a state, what are the factors that effect it? These are questions awaiting further empirical attention.

If we could establish a way of measuring compassion in real time, might we find that the mean value for compassion within a population shifts towards or away from the compassionate end of the distribution as the result of demands placed upon the system by external forces such as the level of workload?
4. Recommendations

- Research the distribution of an operationalised measure of compassion in the general population. Is it normally distributed? Research the factors that increase or reduce compassion in the general population and specifically in the caring professions.

- Research the distribution of compassionateness in the general population. (Is it normally distributed?) And research the factors that increase or reduce compassion in the general population.

- Recruit people who are able to suffer with others and desire to alleviate suffering. Create organisations that minimise the suffering imposed on staff by it, allowing them to suffer with their clients and not be distracted by organisation induced grief. Create organisations that enable staff to alleviate their clients’ suffering.

Organisations: Hitting the targets but missing the point

1. Safe and certain
Organisations, like individuals, operate on dimensions of how safe and how certain they are. Life is, at best, a state of safe uncertainty (Mason, 1993). Organisations may find themselves as uncertain and unsafe whilst striving for the rarely obtainable position of safe certainty. In such circumstances risk assessments and protocols become defence mechanisms rather than useful tools for clients and clinicians.

2. Mind the gap – Management and clinicians
Poor communication is highlighted again and again in most enquiries into serious incidents. It is dangerous when there is disconnection in communication between the culture of management and the culture of clinicians. In such circumstances, each may think that they are communicating and meeting the other’s needs, but in reality they are not. The goals to which they are working are not the same.

3. Who do you serve?
One of the considerations for members of an organisation is: Who do you serve? Is it the Trust, is it the service users and carers, is it the commissioners, is it the Care Quality Commission and Monitor, is it the NHS, is it all of these?

These multiple masters can lead to confusion and further increase the gap between management and clinicians, between clinicians and clients. The Francis Report (2013) highlighted the problem of the goals and needs of the organisation having become too dominant. In the document’s executive summary they reported that in the South Staffordshire hospitals they had found: ‘A culture focused on doing the system’s business not that of the patients’ (2013, p.4). A clinician’s primary duty of care should be to their client. This may bring the clinician into conflict with management. However, this needs not be negative conflict if it leads to open and honest dialogue from their respective positions.

4. Recommendations

- Create organisations that embody safe uncertainty; that change is inevitable but that the organisation is safe.

- Acknowledge the different needs of management and clinical cultures and that the development of compromise and consensus positions between the two is needed. Create an ongoing dialogue between the two with opinion flowing top down and bottom up so that grand rationalist plans are not implemented that do not take account of empirical and lived experience feedback. This should reduce the chances of disconnection between organisational objectives and patient-focused care.

- Have clarity about the multiple stakeholders, for both clinicians and management, in order to appreciate explicitly how the demands of each does or does not fit with their values.

Leadership: Getting the right people, role models and training them well

1 Who buys a ticket?
The Francis Report (2013) highlighted the importance of leadership. In the executive summary it stated that: ‘It is a truism that organisational culture is informed by the nature of its leadership.’ (2013, p.64). So who constitutes the
leadership of an organisation is crucial. However, do the right people come forward offering to be leaders? Do the right people get chosen to be leaders? Should trait models of personality be used in leader selection to make sure that the right people are chosen? The later has been advocated for by researchers in the area, such as Ng et al. (2008). Recently, attention has turned to a trait theory based concept of the triadic personality type, which has significant components of narcissism, psychopathy and Machiavellianism. It has been suggested that people with this type of personality are increasingly thriving in the public sector (James, 2013) as government policies of the last thirty five years have shifted the culture of the public sector from one based on service and duty towards one based on competitive business models.

2. Who does the leader want to be?
When polls are conducted or academics consulted to find out who are considered to be great leaders, the people rated at the top often include: Julius Caesar, Mao, Castro, Churchill, Washington and Ghandi. See, for example, Industry Leader Magazine (2012). These grand, heroic and usually male figures might not be the best for people to model themselves on.

In addition, the very act of being a leader can corrupt and lead to what Owen and Davidson (2009) termed ‘hubris syndrome’, which they see in Thatcher, G.W. Bush and Blair, where the desire for power became all consuming. This may also link to the triadic personality cluster.

3. Do we train our leaders well?
The training that we have offer clinical psychologists in leadership needs to compare favourably to other professions. Psychiatrists are trained to lead and expected to do so. Clinical psychology training courses have improved this aspect of training in recent years. Clinical psychologists in leadership roles need to be effective to become good role models for the next generation.

4. Recommendations
- Take care in the selection of leaders and use evidence-based selection procedures.
- Set up a resource of exemplars of good leadership that are more appropriate for the average person in a healthcare setting rather than grand, heroic figures. Provide good governance in organisations to guard against hubris. The leader must play by the rules.
- Provide quality training in leadership and followership for clinical psychologists at all levels. This training could include the study of the big models of leadership, such as servant and host leadership, in addition to leadership styles for specific contexts, such as being authoritative or coaching, in order to help them find their own authentic personal style. In addition, rather than trying to produce generic leaders it may be better to produce leaders for different tasks and contexts.

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References
Developing a culture of compassion: Can't or won't

Amra S. Rao

We are sitting with our old mother in the nursing home. ‘Of course I’m lonesome for your kids. But it’s not like being in a strange place where you don’t know anymore.’ She smiles, trying to reassure us. ‘There are plenty of people here from good old Willy.’ She adds. ‘Of course, a lot of them can’t talk’. She pauses, and goes on: ‘A lot of them can’t see’. She looks at us through her thick-lensed glasses. We know she can’t see anything but light and shadow. ‘I’m the last of the Mohicans, as they say’. The Last of the Mohicans, Lydia Davis (2013)

This piece by Lydia Davis (2013) reminds me of what can’t be seen, spoken about or heard. One can turn a blind eye to things knowingly or unknowingly, as facing them can be uncomfortable. Adjustment to transitions can be unsettling, as it requires relinquishing places of familiarity and facing of survival anxieties. Embracing the loss of what is known and connecting with change is often challenging, although this may offer opportunities for development and growth. Our paths are often determined by the choices we make at such transitional points.

Turning of a blind eye (Steiner, 1993) is not uncommon in organisations. Reviews like the Francis report (2013) and the report into the abuse at Winterbourne View (DH, 2012) point out malpractice which organisations fail to notice. Goldman (2008) uses a similar case of leadership negligence at SkyWaves Aerospace International to point out the consequences of a culture of ‘no emotions allowed’. Such reports are important markers for what can go wrong in organisations and how this could arise from compromised capacity to hold compassion and care in mind. This paper intends to consider factors such as containment, empowerment, responsible autonomy and internalised accountability to facilitate a culture of compassion. It briefly examines dynamics, which impact such attributes in individuals and groups. The scope of reflective organisations, where leaders invest in containing structures and processes is discussed. Although the focus of the paper is on healthcare, issues explored are relevant to wider settings, as compassion and staff well-being is relevant to all organisations.

Compassion and care in organisations
Capacity to provide care requires a state of mind which has an ability to hold both oneself and others in mind. Engaging with ourselves in a caring role is as important as engaging with the care needs of clients. This interplay between self and other is explored well in Fonagy and Bateman’s (2006) work on ‘mentalisating’. It attends to mental states (beliefs, wishes, feelings and thoughts) which determine what we do. They describe mentalising as ‘the key social-cognitive capacity that has allowed human beings to create effective social groups’. It is ‘a perceiving and interpreting behaviour as conjoined with intentional mental state’ (Allen, 2012). The concept is widely used in clinical settings and is linked with concepts such as empathy, psychological mindedness, and ‘the third position’. Mentalising requires attention to the intentional mental state of others whom we are with physically, psychologically and emotionally. We can all lose this capacity temporarily when...
we disconnect with the awareness that others have a ‘mind’ and treat them as physical objects (Fonagy & Bateman, 2006). This work on mentalising provides a helpful framework to add to the understanding of compassion and how this is compromised in groups and organisations.

Individuals and groups under pressure and faced with anxieties can experience a borderline state of mind where capacity to symbolise and have sufficient distance from the physical reality to pay attention to mental representation is lost. Attempts to understand difficulties are often concrete, assumptive and lacking reference to internal states of oneself and others to understand behaviour. Others cease to exist as having a ‘mind’ representing feelings, desires, intentions, thoughts and needs. Such processes can occur at individual and group level bringing complex dynamics associated with In and Out groups. This compromises the ability to hold a focused compassionate vision, which can attend to multiple perspectives including self, others and the wider context.

Compassionate organisations – what comes in the way

Individuals bring life experiences to work, which, combined with working conditions, impact on their ways of relatedness with the task and their teams. Ability to mentalise is facilitated by conditions which help to process and contain work-related challenges and anxieties. Such anxieties often arise through contact with task and need for collaboration with others (Krantz, 2001). Menzies Lyth’s work (1988) is centred on anxieties associated with the nature of the task and how organisations develop systems/defences to manage them. She examined nursing environments and highlighted how anxieties associated with dependency, survival and personal limits to provide care can be dealt with by rigid adherence to procedures. This can happen at the cost of creative thinking and human contact with patients, as such anxieties can feel unbearable. Whilst errors and incidents in organisations allow space to review practices, anxieties at such times are often pronounced and can get in the way of reflective learning, as exploration of ‘why’ and ‘how’, and looking at the impact of the incident on staff and wider system is often challenging.

Organisations need structures and processes to deliver their tasks safely and effectively. Systems such as strategic vision, policies and forums to communicate and discuss work related matters are required to provide necessary conditions for the work to be done. Problems arise when these systems impinge on capacity to think and mentalise, which is essential to inform practice and learn from experience. Reports such as Francis’ inquiry provide useful insight into how systems can struggle to notice matters of concern and or may choose to turn a blind eye (Steiner, 1993). Findings on failure to care are not surprising to many of us, as public services capacity to contain and sustain a culture of reliable dependency has been under enormous pressures in recent years. The NHS has faced fierce financial pressures within a context of increased public expectations and awareness, enhanced service users’ voice and advances in health and social media technology. This, combined with the quality agenda and evidence based practice, has influenced many recent drivers for change. The pace of change in many services has been rapid. Cuts, redundancies, restructuring, lower staff/customer ratio, pressures surrounding an adequate skill mix, performance targets and stressed work environment are familiar challenges to many public health workers. Although management of change is often marked as important, the time and effort required to pay attention to system dynamics makes this work challenging. A collusive displacement of responsibility can compound this further when such work is handed over to the other, at the cost of increased vulnerability.

This poses the question of whether we can’t or won’t play our part in developing a culture of care, which requires a compassionate mind. In my view, attention to relationship between container and contained is impor-
important for leaders and groups to stay curious about the variations in ‘task in mind’ as well as ‘organisation in mind’. Staff can have a different vision and purpose in mind in connecting with their role, which requires exploration to facilitate re-engagement with the task.

Alongside differences in how we connect with the task and role, group dynamics are often at play at work. Bion (1948) distinguished between ‘work groups’ and ‘basis assumption groups’. The tendency towards work on the primary task is referred to as ‘work group mentality’ and tendency to avoid work on the primary task is called ‘basic assumption mentality’, where the group behaviour is directed at trying to meet unconscious needs of its members by reducing internal conflicts and managing relationships. In one of the consultancies I undertook on change transformation, underlying dynamics around the system change were pronounced. The task of sign-posting patients to the right treatment was shadowed by competition between teams where rivalrous responses came in the way of engaging with what would work for the patient. Experience of suspicion and preoccupation with rules and processes led to flight from work and fight with what felt intolerable. The group remained preoccupied with status and hierarchy, stirring up unspoken competition which impacted on decision-making. Similar dynamics were noticeable in a coaching assignment in the finance sector where flight and fight dynamics were at play as new management remained preoccupied with implementation of new vision for talent management, inclusion and diversity. Little attention was paid to engagement with existing employees of the firm to consider the impact of the management of the new vision on their role, values and understanding of the task.

There is wide ranging literature on what can facilitate containment and effective workplace functioning. Contributions from the systems psychodynamic approach highlights the
importance of looking at operational structures and processes as well as below the surface issues, including:

- Clarity on the primary task (Rice, 1948).
- Clarity of roles (Lawrence, 1977).
- Clear communication and structures of authorisation (who decides on primary task and by what authority?).
- Focus on task orientated activities to mobilise co-operation and valuing of different contributions.
- Workgroups to contain task-related anxieties and impact of work on staff to help developing a self-observing stance to one’s emotions and reactions to others. Such forums can facilitate developing a capacity to hold ‘the third position’, which is a paramount role in processing differences that are feared or seen as threatening.

Change: Opportunity or threat

Invitation to change can evoke mixed responses such as fear and anticipated hope. As mentioned earlier, change can often be unsettling and painful as it requires relinquishing places of familiarity. Thoughtful management of change, with a balanced outward and inward focus, alongside reflection on learning from past and authentic connectivity with the organisational history is vital opening up opportunities for creativity and growth. This involves focusing on tasks as well as paying attention to an organisational mind-set encompassing anxieties, conflicting needs, rivalries, competition and ambition. This is nevertheless challenging as the ability to reflect and mentalise is often compromised at the time of change.

The importance of a ‘transitional space’ to process and grieve in order to open up growth can’t be underestimated. Kubler-Ross’ (2005) stages of loss reminds us of changes individuals go through whilst faced with grieving of what is no more. This work has been extended to organisations to understand the process of change and its impact on individuals and groups, indicating that grief, anger and depression associated with the loss need to be embraced to arrive at a meaningful position where opportunities and growth could be considered.

In my organisational and coaching work, I frequently come across the phenomena of ‘change fatigue’ and feeling of ‘being designed out’, often indicating a disrupted mourning of loss. This results in burn out and affects capacity to engage with the ‘third position’. I notice a particular pattern, where engagement with the task is minimised by delivering bare essentials to do the work at the cost of creativity and work satisfaction. Individual conflicts are often pronounced with abdication of both personal authority and responsibility to look at what is going on.

It is not the scope of this paper to explore such dynamics in depth, it is suffice to say that leaders and managers need to be observant of such driving and restraining forces at work and consider what needs to be harnessed to facilitate staff well-being and engagement with the task. Leaders play a significant part in offering containment in order to cultivate thoughtful and compassionate care with a clear focus. This requires exploration of work priorities and adopting a reflective style that allows looking at work from multiple angles.

A recent article in the *Harvard Business Review* (Golman, 2013) suggests that a leader needs to foster a triangulated focus in order to be effective. This requires:

- A focus on oneself, to have self-awareness and control to connect with direction.
- A focus on others to foster relationships. This requires cognitive and emotional empathy as well as an empathic concern – the ability to sense what other people need from you.
- A focus on the world with a focused strategy and system awareness.

Moving forward: Can’t or won’t

Questions posed by organisational inquiries and recommendations are often challenging and require a system-based reflective approach and a responsible commitment to examine practices. It is vital that organisations attend to structural and procedural changes as well as having a commitment to address processes to uncover ‘under the surface’ issues that affect engagement with the task-focused role assignment. This requires reflection on the part of organisations and the
individuals in them to consider whether they can’t or won’t. Organisations need to take a step beyond the ordinary and embrace the joy and pain associated with the task of providing care, as it involves both satisfaction and possibility of disappointing oneself and others. This entails a triangulated approach at the heart of interaction between people with a focus on task, role and boundary management to attend to the self, others and wider context. Engagement of both leaders and followers is vital for such an endeavour.

What contributes to ‘we can’t and won’t’ requires the collective attention of both staff and leaders to hold responsible autonomy and internalised accountability. There is risk of collusive displacement and abdication of responsibility resulting in a collective flight from the challenge of bringing our individual contribution. Whilst leaders hold responsibility to set up containing structures, a stance of dependency on the other can disconnect us from what role we can individually play. Managing survival anxieties and holding compassion in mind in market of fierce competition, job cuts and fast changing global and political world is not going to be easy. A combined effort to develop a sense of enquiry is needed as well as capacity to hold mentalising under pressure, alongside provision of safety for staff, for the process of learning to unfold. Provision of a protected space for reflection to address the impact of work is vital for developing organisations’ social-cognitive capacity. This can help to develop the capacity to be open, take risks and challenge to connect with responsible accountability towards oneself, others and the organisational task. This requires courage and resilience on the part of individuals, groups and organisations.

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The British Psychological Society
Division of Clinical Psychology

Division of Clinical Psychology Facebook page

The DCP now has a Facebook page.
To get all the latest updates from the Division go to:
www.facebook.com/divisionofclinicalpsychology
THE INTEREST in the quality of compassion in health and social care has expanded in the last few years and has been awarded unprecedented importance following the Francis inquiry report (2013). It has been reported that patients are more likely to talk more about their experiences and symptoms following caregiver compassion (Firth-Cozens et al., 2009). Thus, the ability of healthcare staff to be compassionate may aid the cultivation of the therapeutic relationship, which is one of the best-known predictors of favourable outcomes of therapy (Norcross, 2011). This article focuses on the current work and initiatives at the National Psychosis Unit (NPU) to promote compassionate care among the team.

The NPU is a specialist, 23 bed in-patient unit for people diagnosed with treatment-resistant schizophrenia. It is a long-stay unit, where the patients are often acutely unwell and at times incidents of violence towards staff can be high. Many patients also experience a number of physical health risks (e.g. diabetes, heart conditions), which can require a crisis-driven response from staff. In the wider context, austerity measures within the Trust, sickness rates, and increased target driven workloads mean that the staff may be at high risk of compassion fatigue and burnout. High levels of stress have been documented in NHS mental health nurses (Sherring & Knight, 2009) and this is especially relevant in a psychiatric in-patient ward, where work with complex patients can be both challenging and distressing for staff (Bowers et al., 2011). It is understandible that these factors may leave staff in a position where they are unable to work in the best interests of the patient (e.g. affective attunement to patient; Penn et al., 2004).

Clinical psychologists are well placed to assess, formulate and help manage these potential professional and personal challenges. We view compassionate care as a recurrent task, which requires monitoring and enhanced input when a crisis event occurs to enhance a compassionate perspective leading to quality care. We are currently doing this via two strands: reflective practice groups and team formulation; these will be discussed in turn.

First, a qualified psychologist facilitates monthly reflective-practice group sessions. These groups aim to provide a safe and supportive space to allow open discussions, where staff are invited to reflect on the professional and personal challenges and successes of their work. Research indicates that nursing staff that are stressed are less likely to show compassion towards themselves, which is likely to translate to a lack of compassion towards patients (Gilbert, 2009).

Informal evaluation of our groups to date has indicated that they provide normalisation of experiences, lessen feelings of isolation, and increase openness to experiences and empathy. Staff also acknowledge that there can be a powerful sense of satisfaction gained from such challenging work; termed ‘compassion satisfaction’ in the literature (Figley, 2002).

Second, psychologists facilitate complex case discussion meetings fortnightly;
referred to as ‘long handovers’ on the ward. There is emerging evidence that team formulation is associated with improvements in staff members’ ability to provide compassionate care towards patients (Lown & Manning, 2010) – specifically, increased empathy, confidence and compassion (Goodrich, 2012). The aim of long handovers at the NPU is to improve understanding of the patient’s history and presenting difficulties, and facilitate the development of therapeutic relationships. Berry and colleagues (2008) reported that within an in-patient setting team formulation had a positive effect on staff appraisals of patients’ mental health problems and feelings towards patients. A previous evaluation of staff feedback from the long handovers indicated that they are seen as useful and a good way to learn about patients. However, we have observed that the focus can at times be on action points about ‘what to do with someone’ (Onwumere, 2012), which is not the main focus of such groups.

Given the abovementioned research findings, we are interested in whether the long handovers develop compassion towards patients, such as a stronger sense of empathy, non-judgment, collaborative working, engagement, greater tolerance of patients’ distress, and confidence. This will be assessed through a service evaluation, which includes a baseline period and three-month follow-up. Self-report measures of compassion towards others (Pommier & Neff, 2011), compassion satisfaction and compassion fatigue (Hudnall Stamm, 2009) will be used at these time points. Additionally, a newly devised five-item compassion-based self-report measure will also be administered pre/post each long handover to assess changes in staff compassion towards the patient being discussed. Preliminary findings indicate that, whilst the team have relatively high levels of compassion, they are also experiencing burn-out. Initial indications based on responses to the five-item measure suggest that the long handovers are an effective way of increasing compassion towards patients. Further data collection and analysis is needed to fully evaluate the effectiveness of the long handovers (in preparation). Research and development permission was granted by South London & Maudsley NHS Foundation Trust. This evaluation was also designed in collaboration with the needs of the ward manager and the wider nursing management team, and is in accordance with the six ‘C’s of nursing: care, compassion, competence, communication, courage and commitment – a national strategy from the Chief Nursing Officer for England to build a culture of compassion across the profession of nursing (www.england.nhs.uk/nursingvision/6cslive).

This will be the first evaluation of compassionate care at the NPU and it is hoped findings will highlight the importance of using psychological formulation to develop and nurture a stronger sense of self- and other-compassion within an in-patient setting. The findings are expected to be relevant to developing future research within the NPU and wider Trust.

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A KEY THEME arising from the Francis inquiry report was that of culture of care. This important aspect of service delivery was targeted by the Directorate of Forensic Mental Health and Learning Disabilities (DFMH&LD) of NHS Greater Glasgow & Clyde (NHSGGC) through the decision to develop a package of training aimed at enhancing the therapeutic aspects of the secure environment.

The Francis inquiry report suggested a need for organisations to provide the ‘right’ culture of care. This includes providing staff with the right training and support appropriate to the needs of the patients they are working with, along with recognising the challenges of the job. For staff in forensic clinical settings, this has particular resonance, as the impact of patients’ clinical presentations or histories should be considered. Aspects of offences they have committed can arouse powerful feelings such as disgust or fear, which may impact on patient engagement and interactions. Similarly, there is some evidence to suggest that patient characteristics may contribute to difficulties in providing a wholly therapeutic environment. These may include psychosis and particularly personality pathology (Moore, 2012). In line with the Francis inquiry report, the ‘forensic matrix’ (2011) outlines the need to make staff aware of the challenges of working with this complex client group and to understand the causes of patients’ behaviours. To help address this, a therapeutic milieu training programme was developed within the DFMH&LD NHSGGC. The development of the training package was led by clinical psychology, with contributions from other professional groups, and was drawn from psychological theory and the existing evidence base. The package of training was supported by the senior management team and incorporated into the Directorate learning plan, with a target of training approximately 80 per cent of staff within an 18 month period.

The training programme itself was designed to raise awareness of the influences on patient behaviour, the therapeutic environment and the nature of interventions delivered within the Directorate to promote patients’ recovery and risk management, along with raising awareness of communication issues and staff-patient interactions. The training was not didactic but encouraged reflection and discussion. The specific areas covered in the content of the training included:

- Considering what was meant by the term ‘therapeutic milieu’ and whether this was a ‘rebranding’ of something familiar.
- Thinking about what it was like to be a patient in the forensic mental health setting including an introduction to formulation.
- Consideration of how patients’ presentations and characteristics can make us as staff members feel (incorporating the effect of the environment, reflecting on the potential for a ‘them and us’ culture and the impact of this on both staff and patients, and working with challenging or difficult behaviours).
- And finally, participants were encouraged to reflect on effective communication and appropriate disclosure, along with promoting recovery whilst managing risk, seen as two sides of the same coin.

During development of the programme, current and former in-patients were invited to comment on the content of the training materials in order to ensure that their experiences of their care and management were reflected. Furthermore, the material was...
piloted with a multidisciplinary group of professionals who provided feedback, both on the content of the training and on delivery. These processes feed into a revision and refinement of the original materials into the programme as it now stands. The model of training was to target whole multidisciplinary teams as a group, in order to help team members reflect on the individuals under their care, rather than on more abstract case examples. A monthly training schedule is now in place for the forthcoming year.

The experience of delivering the training was a positive one, with participants describing the benefit of a multidisciplinary approach to the training, and appreciating the range of experience and seniority amongst facilitators and participants. It appeared from the feedback that participants really valued gaining a better understanding of patients’ behaviour through discussion about their background and life events, in the context of some psychological theory to support their understanding, such as attachment theory. As a facilitator, this was particularly rewarding, in that participants remarked that considering formulation helped them to remember to reflect more on individual patient’s strengths and interests, and that this helped with making interactions generally more therapeutic. With the roll out of this training the aim is to support staff to feel more valued and informed, and subsequently foster a culture of care that meets the needs of the patients in forensic mental health settings. Further developments may include reinforcing the key messages of the training through the use of reflective sessions for staff, and also providing fora for patients to reflect on their own experiences of the therapeutic milieu, and for this to be incorporated into ward plans.

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I WRITE this from Toronto where I am on a career break from my post as joint head of a child psychology service. This is relevant, firstly because after 20 years in the NHS in a job I am passionate about, my frustrations were such that I leapt at the opportunity to have some time out. Secondly, I have been afforded the space to reflect on 12 years as a manager – something that never felt possible when I was working, despite the best of intentions. Finally, spending time in Canada, I am struck that there may be things we can learn from the culture here.

For the majority of my career I have worked in a child psychology service where the core values have been explicit and have shaped every aspect of our practice. This predates my leadership role, and indeed, was the incentive to take up the mantle. With such a clear rationale and the support of an equally passionate job share partner and team, it has been easier perhaps to crystallise those values and to spot when they come under threat.

The values have remained resolute throughout my experiences of working with highly distressed children and families, in a number of core and specialist teams, with an evolving evidence base, and all the turbulence, fads and fashions faced by the NHS. They are:

1. That every child is unique.
2. That the family and the systems around the child are central to our understanding.
3. That the child and their family are the experts on their own experience.
4. That children deserve the opportunity to have a normative, contextual and developmental understanding of their distress.
5. That the language we use is very powerful and must be considered with care.
6. That the least possible contact with professional services, the more empowering the experience that we are our most important resource and need to be nurtured if we are to nurture those we work with.
7. That we are a scarce resource and have a responsibility to target our specialist skills to maximal effect.

It is my assumption that there is nothing particularly controversial in these values, and they would be commonly held by psychologically minded professionals throughout health. Indeed, in my discussions with the vast majority of multidisciplinary and managerial colleagues there is generally consensus regarding the above; and they can usually be found embedded in strategic documents that shape our public services.

Despite this, when it comes to service delivery, much of my career has been spent either arguing in their favour or defending them against attack. Indeed, I would characterise the majority of my professional life as a manager as ‘swimming against the tide’, which is perhaps why I felt so ready for a break.

Now that I have the time, I am more able to reflect on the mismatch between what people clearly believe and how it actually feels on the ground. Maybe my thoughts can offer some insight into why the atrocities that led to the Francis inquiry happened, despite us knowing that most people who work in healthcare do so because they genuinely do care.

I will also argue that psychology, because of the nature of our training, is in an advantaged position to be able to offer some potential solutions.

Core values and the NHS: Reflections with the benefit of distance
Liz Gregory
Value 1: Every child is unique
Only the brave would deny this, yet as clinicians we are constantly put under pressure to conform to standardised formats and ‘one size fits all’ solutions. The rationale is obvious – it is simpler, cheaper, ensures consistency, guards against idiosyncratic practice and reduces negligence claims. The risk, of course, is that it has the potential to depersonalise and even dehumanise the healthcare experience. The alternative prospect, of course, that every user of the NHS requires a completely individualised service, is equally terrifying for us all in health. This is particularly in light of the pressure we are under and the constant message that demand is only going to grow.

I would argue that clinical psychologists are able to adopt a helpful position in respect of this dichotomy. We start and finish with the premise that everyone is unique, but equally we are diligent in our reference to both the evidence base and the clinical experience to ensure the most efficient interventions are identified. We are trained to anticipate that the journey will be dynamic, requiring constant adjustment. We trust that it is through a relationship that change will be achieved, and we have many skills to help us to achieve this.

It is unrealistic to roll out similar training to all professions but there are some basic principles that can be shared. For example, listening and responding to feedback, and having the confidence to change direction in the middle of a process. Interview questions such as ‘how will you know if today’s appointment has been helpful?’ can facilitate an individualised approach regardless of the endeavour.

Value 2: The family and the systems around the child are central to our understanding
This is most relevant to children’s services, of course, but it may have a wider utility. The traditional model of healthcare is very individualised – despite often losing sight of the individual. However, as psychologists we are trained to understand that everyone exists within a context, and that this context may be more or less helpful to the healing process. We have the skills to manage multiple perspectives, and frequently deliver interventions indirectly through carers or staff.

These are unfamiliar concepts within the medical model, and yet they have the potential to be highly relevant. For example, from family myths about illness, to the accessibility of the school toilets, there are an infinite number of factors that can interfere with the effectiveness of treatments. Questions such as ‘who is most likely and who is least likely to support you in this?’ can help to identify potential barriers, and psychologists can have a role in containing the commonly held fear of ‘opening a can of worms’.

Value 3: The child and their family are the experts on their own experience
As psychologists this is a concept that is central to our profession, and it is now gaining a real momentum in the general healthcare arena. We are well placed, therefore, to support the development of user involvement and methodologies such as co-construction. We can also have a role in containing another common anxiety that this will generate unrealistic demands.

This reminds me of my own experience of an admission to a medical ward 15 years ago. The general hygiene levels were very poor, people were left in soiled beds and I overheard conversations between staff about ‘difficult patients’. After I had been discharged I mentioned my concerns to a doctor from a different organisation. Despite being one of the most caring and diligent physicians I know, the response was that it was that ‘a hospital and not a hotel’. The comment was fuelled, of course, by feeling defensive on behalf of overstretched nursing and medical colleagues, and overwhelmed regarding where the line gets drawn. Again, I believe that psychology has something to offer this dichotomy. We are trained to search out solutions in ‘all or nothing’ situations, trusting that a middle ground can be found.
Value 4: Children deserve the opportunity to have a normative, contextual and developmental understanding of their distress

Value 5: The language we use is very powerful and must be considered with care

These values are perhaps most relevant to mental health services. However, again I am minded of a story that suggests a much wider application. I worked with a boy referred because of ‘extreme behavioural difficulties’. His mother was the victim of severe domestic violence, often witnessed by the boy. I saw my role as acknowledging to the mother that her son was presenting her with a challenge, but at the same time helping her to understand how his experiences were relevant to his behaviour. This inevitably implies that choices in her life may have been a contributing factor – a devastating prospect. It is tricky terrain, but common ground for child psychologists, and we were making tentative progress.

In the meantime, in a desperate attempt to help a desperate situation, the GP had written a number of referrals. The mother duly attended a paediatric clinic with her son and he was diagnosed with ‘conduct disorder’. This diagnosis simply confirms that the child has significant behavioural difficulties. However, for the mother a ‘disorder’ implied that the problem lay within her child after all, and no doubt relieved that she was not ‘to blame’, she cancelled future appointments with me. The paediatrician also discharged the boy, unaware of the impact of the diagnosis on the mother’s understanding of her son’s behaviour. Sadly, I met the boy again a few years later in foster care, placed there he told me, because he had a ‘behaviour disorder’.

This story illustrates a number of points that do not need to be hammered home. The intention, rather, is to suggest that the NHS itself (that’s us), may perpetuate some of its (our) own problems. The model of care can create expectations that, in turn, we feel obliged to fulfil. As psychologists, I am certain we have our blind spots too. However, we do bring a systemic understanding that can be particularly useful in unpicking some of these tangles. Indeed, we can often be of most use to the teams and services we are not a part of, as we have the opportunity to adopt a meta-perspective, looking at them through fresh eyes.

Value 6: The least possible contact with professional services, the more empowering the experience

I would suggest that this value runs counter to the dominant model of ‘care’ in health. As psychologists, we are trained to see that the lightest touch necessary results in the most effective interventions. I rarely observe this in other disciplines, who often report ‘feeling guilty’ if they haven’t ‘done something’, especially when waiting lists are long. If we could help in shifting this, then we would go a long way towards changing the culture of dependency that is currently crippling the NHS. Sharing our frameworks for psychological consultation, along with therapeutic models such as motivational interviewing and solution focused approaches, are powerful tools in this process.

Value 7: We are our most important resource and need to be nurtured if we are to nurture those we work with

This is clearly something that the health service wants to believe in, and yet time and time again staff feel undervalued. Training budgets were the first to be cut; posts are held vacant to ‘save’ the financial bottom line and staff feel under constant pressure to achieve more with less. As psychologists, we certainly have the tools to help in this area, but there really has to be some investment here if staff are to experience it as anything other than tokenism.

Value 8: We are a scarce resource and have a responsibility to target our specialist skills to maximal effect

This too is an area where I would suggest psychology has something to offer the general healthcare landscape. Stepped care, consultation and training are all models of service provision that we embrace, alongside ongoing evaluations to ensure our interventions are targeted effectively. We are passionate about early intervention, and have a track record in developing ‘spend to save’ models of care.
Now to Canada, and why my experiences here feel relevant despite no contact, as yet, with health services. It certainly seems to be a softer, warmer and more patient society. Even the large metropolis that is Toronto sees itself as a city of neighbourhoods that care. Reference is often made to Canadian values, and there is a strong sense of identity that includes tolerance and citizenship. I am sure it is not perfect, of course, but it is both palpable, and impressive given the enormity and diversity of the country.

At the heart of this paper is the concept that if the NHS adopts the right core values, then decision making, regardless of the size and nature of the task, becomes clearer and more coherent. If, as citizens and employees, we were able to identify the values we are all prepared to sign up to, I am certain that common ground would emerge, and with that a template for a model of health care we could all feel proud of.

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Thursday 13 November 2014, 9.30am–4.30pm (Registration from 8.45am)

The aim of the day is to promote education, awareness and discussion around the provision of psychology services in the North West amidst a changing political and economic backdrop. This will be facilitated by presentations and workshops. In addition, there will be the opportunity for regional networking and updates regarding regional Branch activities.

DCP member £35 (£29.17 + VAT) | Society member £80 (£66.67 + VAT)  
Non-member £115 (£95.83 + VAT). Lunch and refreshments will be provided.

To book or for further details go to:  
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All queries, please e-mail MemberNetworkServices@bps.org.uk with ‘Better Together 2014’ in the subject line.
Preventing organisational fibrillation: The role of the development of supervision skills

Sue Walsh & Liza Monaghan

As clinical psychologists we are aware of the importance of supervision in the development of thoughtful, self-critical, self-aware clinical practice (Scaife, 2009; Milne, 2009; Fleming & Steen, 2011). However, despite increasing expectation that this is a mandatory aspect of good professional practice (CQC, 2013) on the ground experience suggests that: (a) space for supervision is under attack; and (b) those staff who face the most emotional disturbance at work receive least supervision/emotional containment in their work (Bowers et. al., 2011). This paper aims to restate and reconstruct an argument for the centrality of supervision skills training which more effectively takes account of the organisational contexts in which we work currently and outline the development of a distance learning course created to meet the training needs of a local workforce.

We have been aware of the impact of the organisation upon the capacity of NHS staff to care for the sick and vulnerable ever since Menzies Lyth’s study of nurses working in a general hospital (Menzies Lyth, 1959). The study revealed that the primary work task of nurses was to bear the fundamental anxiety of caring for our loved ones, of facing the emotionally overwhelming experience of caring for the sick, the dying and the fearful. For staff coping with these overwhelming experiences, with few psychological tools to help make sense of them, the patient became a series of technical/professional tasks to be completed. These unconscious defensive strategies enabled the staff member to emotionally distance themselves from the turmoil of caring for the sick. The work role became about ‘doing to’ not ‘caring for’.

This sense of ‘doing to’ rather than ‘caring for’ appears to be a potential byproduct of current organisational change processes. The Mid Staffordshire inquiry, chaired by Robert Francis, revealed that caring for sick people become driven by the need to complete tasks and protocols, and meet financial and business deadlines (Francis, 2013). Patients’ needs became a potential distraction. Although as professionals we are all responsible for our own actions, it has become increasingly clear that the capacity of the organisational system to hold onto genuine compassionate care for patients, their families and staff can be compromised by the need to attend to protocols and targets.

All NHS services are undergoing threat and change and our work contexts are in a state of flux and anxiety. The political context of the NHS is subject to widespread change – the industrialisation of healthcare, the rise in chronic health conditions, the reprioritisation of funding, and increasing service splits and competition (Cooper & Lousada, 2005). What does such disruption and change do to staff capacity to think about the clinical needs of vulnerable patients? Kahn (2005) argues that sustaining resilience in caring systems is created by a set of shared unspoken beliefs among members which he describes as the ‘cultural skin’. Such skin is made up of the strength of work relationships, the importance of an emotional working life (engaging openly in a process that tolerates how staff feel about the work and each other), and a sense that the organisational world is manageable (that work difficulties can be faced and understood). Business priorities are taking over our thinking about our patient and work relationships and needs.
Preventing organisational fibrillation

Work systems are created in which thoughtful containment is replaced with fearfulness. Rushing mindlessly about (the organisational fibrillation of the title), unable to stop, is replacing ‘thinking about’ the vulnerable other. Reflection is being replaced by the organisational imperative to avoid punishment, to tick boxes and try to keep your job safe.

We need to reaffirm the role of supervision when connection with others becomes hard. We need to prioritise our understanding of what happens to staff capacity to think when they are under constant change and threat.

Maintaining our supervision structures and engendering thinking spaces for ourselves and other professionals becomes a central and moral task. The importance of embedding learning within and about the system in the service of patients and staff is a central aspect of supervisory practice. One of the key findings from Francis was that the failure to build a positive work culture and repeated service re-organisation and disruption directly influenced unfeeling and dangerous work practices.

In the context of service disconnection and fear, the creation of supervision systems become key to holding onto staff capacity to think and reflect about patient needs. As clinical psychologists we should be developing supervision skills in ourselves and others which make sense of the needs of the organisation, the needs of the staff and the needs of the patient, because all interact to create systems which care or systems which harm. The reasons for organisationally informed clinical supervision are: organisations are networks of relationships, work is an intensively emotional experience, psychologically harmful processes emerge when systems and teams become fearful and work problems become pathological the more energy is given over to managing fear than to thinking. Supervision is about thinking together with another. Surely it is not beyond our wit to be kind and thoughtful about, and with, each other in the context of facing wide-ranging healthcare reforms (Ballatt & Campling, 2011).

Restating the case: Why is supervision so important?

Supervision of healthcare staff, especially in the early years of practice, is widely accepted as being important for professional development and to ensure the best possible care for clients. Some professions have long required practitioners to have ongoing supervision throughout their careers. High profile reports about the failure of professional practice and reflection in the care of vulnerable patients have recently highlighted the need for the development of clinical supervision skills (CQC, 2013). Evidence suggests that how staff understand and manage the emotional interactions between themselves and their patients impacts upon their ability to provide service users with effective care at times of crisis (Bradshaw et al., 2007; Maban et al., 2012). Effective supervision provides staff with a thoughtful, reflective space to make sense of what is happening between themselves, the client and the caring system without recourse to hidden and more destructive responses. To hold onto compassionate working practices with our most vulnerable patients, staff require compassionate thinking spaces themselves. Effective supervision thereby enables the staff member to better hold in mind the needs of the patient.

Our experience as clinicians in the NHS suggests that supervision may be poorly understood and is the first thing to go when staff feel busy or overwhelmed. In many NHS systems it has become corrupted as a tick box exercise to ensure the completion of annual leave and staff sickness records. Reprioritising the development of self-aware, self-reflective clinical supervision skills for clinical staff throughout the NHS needs to be maintained as a strategic priority.

Development of training course

In light of this thinking we have developed a distance learning supervision course based at the University of Sheffield. When developing the course our aims were threefold: to promote self-reflective and self-critical learning as an underpinning of effective clinical supervision and to thereby enhance the work performance of course participants; to create a
well-crafted, useful and robust qualification for a group of multidisciplinary NHS staff who are often overlooked; and to embed and extend the learning to support NHS systems to change/reprioritise the delivery of high quality supervisory relationships in specific neglected work areas. In this way, individual learning was connected to system change.

The complexity of mental health service user need, distress and challenging behaviour is most evident in in-patient and complex care settings. Our interest in supervision coincided with a local Trust’s initiative to develop training for staff in these settings and this led to the creation of the Postgraduate Certificate in Clinical Supervision for In-patient and Complex Care Settings by distance learning. As far as we are aware this is the first training programme nationally which specifically addresses the supervision needs of staff working with this client group. The underpinning values of the initiative were to provide support for staff carrying out difficult emotional work (a restorative function), to ensure that workers are staying within ethical and professional boundaries (a normative function), and to help the development of knowledge and skills in the workforce (a formative function). Participants who have enrolled on the course to date are from nursing, occupational therapy, social work and clinical psychology backgrounds. All participants need to be active supervisors and the majority to date have been in leadership or management positions (e.g. ward managers). At the same time, learning at an organisational level was maintained by the creation of a reference group of senior staff within the local NHS Trust, which has helped to shape the development of the course and support its impact within the organisation.

The course is run with an emphasis on applied adult learning and course materials are tailored to meet the needs of a multidisciplinary workforce. It is aimed at working practitioners and is therefore multi-modal; combining face-to-face teaching, web-based learning and regular tutorials. The assessed coursework combines a focus on day-to-day practice with the integration of existing skills within an online community.

**Learning to date**

We are now on our second intake of the course and have conducted a small-scale evaluation informed by a Return on Investment (ROI) framework with our first intake. Although based on small numbers (nine people completed), results suggest positive and significant individual learning with concomitant impact on clinical practice. Staff who have attended the course report returning to their areas of work with enthusiasm, and new skills to influence changes at ward level and beyond. Staff are reporting that they feel they have the skills to change systems and are working up plans in each of their areas (wards and teams) to develop supervision systems and processes. The evaluation is ongoing with our second cohort beginning May 2014.

One of our key learning points has been the importance of support for staff within their organisation. In addition to practical support (e.g. in the form of study leave, access to Learning Beyond Registration funding) our view is that learning across professions and the organisation has taken place because the course is supported and embedded within an NHS reference group. This vehicle has enabled a rethink of wider Trust supervision systems and processes to take place. The reference group is a multidisciplinary forum that actively reviews the efficacy of the course in meeting Trust goals as well as providing a forum to widen the organisational impact of the development of supervisory skills. This supports participants to raise the question of ‘what needs to change in order to embed learning and development in the culture of my organisation?’

Having a course that provides academic depth has emphasised the importance of the delivery of thoughtful and self-aware supervision, and is encouraging others in small steps to see such learning as providing a set of necessary skills to do the job of caring for highly distressed patients. This educational initiative...
Preventing organisational fibrillation is in effect reprioritising the centrality of the caring relationship; one in which both patient and staff feel safe.

Summary
It is argued that effective, well-informed supervisors are crucial to the development of safe reflective practice and therefore the management of patient risk (Bond & Holland, 2010; Hawkins & Shohet, 2012). Clinical supervision is a mandatory aspect of mental health professional practice and is one aspect of the regulatory process for professional registration. However, clinical supervision has often been conflated with managerial tasks and reflective space is sometimes difficult to prioritise in busy and high risk environments. The aims of the Postgraduate Certificate in Clinical Supervision for Inpatient and Complex Care staff by distance learning are to deliver high quality clinical supervisory training and to provide a clinically useful skills development opportunity for multidisciplinary NHS staff who work with the highest levels of patient distress. Primarily, maintaining the priority of clinical supervision can only take place if we, as clinical psychologists ensure that the systems in which we work continue to prioritise both clinical and organisational thinking spaces in the face of a business imperative.

Authors
Sue Walsh & Liza Monaghan, Joint Directors of Clinical Practice, Clinical Psychology Unit, University of Sheffield

IT HAS BEEN an especially active time for faculties since the summer break. On 25 September the DCP Leadership and Management Faculty held its annual conference in York, where they continued their work on ‘A comprehensive model of psychological services provision from primary care to complex presentations and populations’. The faculty are working on some innovative and creative ways to represent this in imaginative diagrams currently titled: ‘The River’, ‘The Street’ and ‘The Flower’. This is still a work in progress, but it promises great things.

As part of this event copies of the Faculty-led publication National Mental Health, Well-being and Psychological Therapies – The role of clinical psychology: A briefing paper for NHS Commissioners were distributed. Copies of this are also available from the Society’s online shop (http://shop.bps.org.uk/national-mental-health-well-being-and-psychological-therapies-the-role-of-clinical-psychology-a-briefing-paper-for-nhs-commissioners.html).

Psychosis Faculty continue developing the narrative

IN A FURTHER positive development by DCP Faculties that should lead to better service user and carer focused compassionate services, Thursday 4 November will also see the Psychosis and Complex Mental Health Faculty build upon their successful and sell out ‘Developing the Narrative’ event from last year with this year’s ‘Developing the Narrative 2: Putting the new narrative into practice’. It will be held at the Society’s London office on Tabernacle Street, London.

In the morning there will be a series of presentations on how people are developing the narrative in innovative ways. Sheena Foster, experienced campaigner for the rights of carers, will present with Faculty Chair, Isabel Clark, on mutual understanding. Lucy Johnstone, formulation guru, will give a talk on how formulations can be used as an alternative to diagnosis. Russel Razzaque, mindfulness and open dialogue researcher, will explain how the Open Dialogue approach is a way to take clinical work in a new direction, and Katie Mottram and Katie Field from the Spiritual Crisis Network will present an alternative way to understand and work, with some of the experiences associated with psychosis.

The afternoon will feature a series of workshops by the morning’s presenters. In addition, there will be workshops by Carol Valenejad, trauma specialist, on ‘Making research ideas a reality’; by Hugh Middleton, psychiatrist and Professor of Sociology and Social Policy, and
colleagues Duncan Double, Carl Beuster and Selma Ibrahim, on ‘Sharing clinical and statutory responsibility to promote recovery’; and by Charlie Heriot-Maitland, psychosis and compassion researcher, who will present on ‘How we can learn lessons from the anomalous experiences of non-clinical groups’.

After tea, the New Paradigm Alliance will explain who they are and what they plan to do, and share their manifesto with attendees. Finally, there will be the Faculty’s AGM.

Isabel Clark, the outgoing chair of the Faculty, described the event thus:

‘Our aim in this conference is to move the “beyond diagnosis” debate on in a practical fashion, by showcasing clinical examples of how it can be done, and forging an alliance with other professionals, service users and carers to change the thinking around mental health within services and for the wider public.’

To book, go to: https://response.questback.com/britishpsychologicalsociety/pcmhanual14. The event is free to all faculty members and a lunch is provided. Any queries please contact MemberNetworkServices@bps.org.uk with ‘PCMH Narrative 2’ in the subject line.

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Stuart Whomsley
DCP PR & Communications Lead

The British Psychological Society

Division of Clinical Psychology

Now available on the BPS Shop
Safeguarding and Promoting the Welfare of Children

This recently revised position paper outlines the professional practice framework for all Chartered psychologists in relation to safeguarding children and young people.

FORMULATION is a ‘core competency’ for clinical psychologists in the UK, and correspondingly, Johnstone and Dallos’ text, now in its second edition, has become a cornerstone of British clinical psychologist’s thinking and training.

This latest version adds chapters on ‘personal construct formulation’, and formulating in teams, and in health-care settings. These latter two will be particularly invaluable for the real-life application of psychology. What’s the use of rethinking health and mental health problems if it is only done by one professional among many? These chapters are also bracingly practical, dealing with many of the everyday essentials of helping a whole team to reach a working understanding of service users (and openly acknowledging this may not always be possible).

A final chapter deals with the controversies related to psychological formulation. Johnstone here addresses the question of whether formulation is ‘evidence based’, concluding frankly that it is not. Though she is quite right to raise the question of empirical validation (a problem which surprisingly few researchers have taken on, maybe because of the conceptual difficulty it presents), there may be other ways to skin the validity cat. Psychological formulation is (as Johnstone is careful to point out) a process for drawing inferences about a person’s psychology. Cannot such inferences be in themselves more or less valid, depending on the manner in which they are drawn and the premises from which they begin?

Johnstone approvingly cites Gillian Butler’s statement that a formulation is a set of ‘hypotheses to be tested’, but this notion needs to be further built in to the way we make our formulations. If I could change this book in one significant way, it would be by integrating more detail on the use of ‘risky prediction and refutation’ as a form of hypothesis building in formulation, consistent with the ‘local clinical scientist’ model (Stricker & Trierweiler, 1995).

Another key issue in the text is the distinction between ‘usefulness’ and ‘truth’. Johnstone suggests formulation should concern itself with the former, whereas diagnosis aspires to the latter. I think formulation can be more ambitious. Presumably there is a fact of the matter about any given individual’s
problems, which the clinician can more or less accurately capture in words. Is there some benefit to be gleaned from constructing stories that ignore veracity, or is it more likely (as this reviewer suspects) that ‘truth’ tends to bring ‘usefulness’ along with it, such that the more we know about a particular individual (and they about themselves), the more able we are to help them?

This is an immensely useful book; practical, creative and still unique in its particular coverage of psychological models. Perhaps only Tracy Eells’ *Handbook of Psychotherapy Case Formulation* (2010) covers more territory in a single volume, but that big book lacks Johnstone and Dallos’ volume’s specificity for a UK health service context.

**References**


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**Clinical Perfectionism**

**Roz Shafran** Professor of Translational Psychology at University College London and founder of the Charlie Waller Institute of Evidence-Based Psychological Treatment

**BPS London Office, 30 Tabernacle Street, London EC2A 4UE**

**Thursday 27 November 2014, 10.00am–4.30pm (registration from 9.30)**

‘Clinical perfectionism’ is a highly specific construct which can often pose problems in routine therapeutic practice. The core psychopathology of clinical perfectionism is an over evaluation of achievement and striving that causes significant adverse consequences. It is implicated in the maintenance of psychopathology, in particular eating disorders, anxiety disorders and depression.

Professor Roz Shafran will provide a cognitive-behavioural analysis of clinical perfectionism and the factors that contribute to its maintenance. Relevant research literature and current evidence-base for interventions will be provided. By the end of the day, participants will learn how to assess clinical perfectionism and determine when it may warrant a specific intervention. They will also be familiar with relevant cognitive-behavioural strategies. The workshop will be interactive and include both experiential and didactic teaching and videos. Participants will have a chance to discuss their own cases.

*This is a free event for DCP members only. Places are limited, so please book early. This event is being financially supported by the DCP London Branch, which has invested in it for the benefit of its members.*

To register go to: [https://response.questback.com/britishpsychologicalsociety/qvbq7huuvz](https://response.questback.com/britishpsychologicalsociety/qvbq7huuvz)

All queries, please e-mail MemberNetworkServices@bps.org.uk with ‘Clinical Perfectionism 2014’ in the subject line.
Notes from the Chair

Richard Pemberton

Manchester DCP Executive Committee meeting
The recent DCP Executive meeting in Manchester was all about steering a progressive course and keeping us on track to build the more coherent and influential professional organisation that we so obviously need.

The headlines from the Manchester meeting include:

- establishing for the first time a UK-wide database for clinical psychology;
- signing off and rolling out our new strategies for Experts by Experience and for Equality and Diversity;
- a new plan to engage and bring trainees into membership;
- concrete steps to improve our media profile;
- the next stage of our work on classification;
- strengthening our links with the English Care Quality Commission;
- the priorities for the new, soon to be appointed, England policy officer;
- planning for this year’s Glasgow 14 conference, and next year’s 50 Years of Clinical Psychology conference, and celebration in London and throughout the country; and
- building cross-nation and cross-divisional momentum on Francis, Winterbourne and Andrews.

Details of the agenda, draft minutes and associated papers can be accessed on the DCP website (www.bps.org.uk/dcp).

Devolution and the lack of coherent English structures
The Division and the Society in general are relatively well organised in Northern Ireland and Scotland, and are getting stronger in Wales. All three have their own DCP executive committees and relationships with their own governmental bodies. In England, we mirror Westminster, in that we don’t have an English executive. We also have the same problem and tensions around the fact that England is so much bigger than the other three nations. London and our North West branches, for example, both have more DCP members than the entire combined membership of Scotland, Northern Ireland and Wales. Given the new devolved decision making, the scale of the job cuts and dislocation of health and social care in England, we have been working hard to strengthen our English branch structures and our links with training courses and heads of psychology and are on course for setting up an English Executive group. This may sound bureaucratic and complicated, but we need effective political structures in all four nations as soon as possible.

Preventing the closure of one of our training courses in the West Midlands
Working closely with the local heads of psychology and training courses, we have managed to prevent further cuts to training commissions in the West Midlands. The training commissioning group there has used savings from cutting clinical psychology training places to fund a programme of psychological therapy skills training across NHS adult mental health services. We allocated additional funding to our West Midlands branch to produce detailed and up-to-date NHS and independent sector workforce data. We demonstrated the flawed nature of the data and workforce modelling that underpinned it. The majority of West Midlands trainees currently don’t even go into adult mental health jobs. If the second round of planned cuts had gone ahead a whole training course would have been lost. We now need to try and get the original cuts reversed. This
also highlights how we need to re-establish our role as a core senior clinical profession across healthcare generally, rather than identify overly on a narrow role in adult mental health as psychological therapists.

The West Midlands work has been helpful to East of England branch members who have also had to respond to threats to commissioned training places. Alison Longwill, who did the detailed work for the West Midlands, is helping us pull together a national database across all care groups and a system for regularly updating it. Her full West Midlands report and can be accessed on the DCP website (www.bps.org.uk/networks-and-communities/member-networks/division-clinical-psychology/resources).

A comprehensive psychological services model
We don’t just need quality workforce data – we also need a shared vision for the future psychology and therapy workforce. The recent Leadership and Management Faculty event in York started to paint this picture. The West Midlands work also helpfully highlights the impact of the loss of leadership posts on professional governance, safety and access to psychological services.

Postponed elections and the Society
Jamie Hacker Hughes, the Society’s President Elect, attended part of the Executive meeting. He is a clinical psychologist and ex-chair of the Campaign for a Royal College of Psychology. His visit was timely as we are still under the moratorium that the Trustees have imposed on our recompense arrangements. These enable us to recompense employers for some of the time elected members spend on DCP and Society business. The record of our agreement with the Society and trustees about these arrangements back in 2006 cannot be found. Graham Turpin kept the documentation we submitted at that time and which produced the recompense arrangements we have enjoyed since then. The trustees have instigated an urgent review of these arrangements and their policy. If you are on our main e-mail list you will have received a separate notification about this. If you haven’t, the details of our recent submission to the trustees and the interesting history can be found on the DCP website (www.bps.org.uk/dcp). This is not as ‘Alice in Wonderland’ as it may seem. The trustees are understandably keen to reduce internal fragmentation and increase the influence of the Society. It is, for example, unsatisfactory that the DCP Faculty for Children, Young People and their Families and the Division of Educational and Child Psychology are not working together within a joined up BPS child and family evidence policy and practice strategy. It is also, for example, problematic that English home branches have no common terms of reference. We have been developing our branches across all four nations in a way that explicitly attempts to link up practitioner psychologist groups but in reality the current laissez faire set up is often distinctly Heath Robinson. Jamie Hacker Hughes is leading a review of membership sub-structures in the Society and we will be contributing to this.

The worst case scenario is that we lose our ability to recompense key posts, and as a consequence the ability to build a professional and effective clinical psychology operation. The best case scenario is that our efforts are complemented and strengthened by sitting within Society processes and structures that take us all forward. In the short term we have had to postpone the elections for some of our key leadership positions and will be asking the current post holders to say in place until we are clear what we are able to offer people who put themselves forward for election. Apologies for this unexpected and highly unsatisfactory state of affairs.

Francis
As highlighted in this special edition of Clinical Psychology Forum we have been working closely with other divisions on our contribution to the issues raised in the Francis Report. We’ve had excellent Francis linked events in all four nations. Many thanks to Al Beck and Andrew Hider, and to Jo Hemmingsfield and the Leadership and Management Faculty, who have kept going against a number of
Notes from the Chair

strong headwinds to get this together. Issues of quality governance, leadership, staff well-being and service user involvement have always been integral to the profession so we are well placed to shape the debate and improve practice. Thanks also to Beth Parry Jones, DCP Wales Chair, and the Welsh DCP Francis team for their work on the Francis and Andrews Cardiff conference, which has attracted substantial cross-disciplinary interest in Wales (www.bps.org.uk/events/post-francis-and-andrews-psychological-approaches-advancing-compassionate-healthcare-delivery-wales).

Whistleblowing
I have personal experience of the risks and heavy pressures of whistleblowing. It is rarely easy or straightforward to challenge poor or abusive practice. This can be especially hard in particular organisation cultures. We know many health and social care organisations can easily lapse into authoritarianism and a culture of bullying. This Care Quality Commission independent report into their own well documented problems is well worth reading (www.cqc.org.uk/content/cqc-publishes-independent-report-bullying-and-harassment-order-learn-lessons-and-make). The British Psychological Society has produced its own position paper on whistleblowing in response to Francis’ consultation on Whistleblowing in the NHS: Independent review (www.bps.org.uk/bpslegacy/cp?frmAction=details&papierID=1347&RegionID=0&IYear=0&open=). It helpfully details the literature but doesn’t suggest how we can increase support to members who are struggling to get their concerns about the practice of colleagues or services properly addressed. We need to have our own ‘duty of candour’ debate. Your professional body is here to offer advice about just these sort of matters and you should feel free to contact any of the divisions’ officers as listed on the inside back cover of CPF.

The theme of compassion care will also feature next month at our Glasgow Annual Conference. Paul Gilbert is giving a keynote and public lecture. If you haven’t already had a look at the programme you can access it on the main BPS website (www.bps.org.uk/dcp2014). Come and join us.

Last but by no means least, on 27 November we have organised a high profile London launch of our Understanding Psychosis and Schizophrenia report. Anne Cooke and the group who have worked so hard to produce it should get a medal. It sets a new standard for the quality of our publications, but also for the way we publicly promote our work and contribution. Details of the launch event and the document can also be found on the BPS site (www.bps.org.uk/networks-and-communities/member-networks/division-clinical-psychology/understanding-psychosis-and-sc).

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