NHS Staff and Learners' Mental Wellbeing Commission

February 2019

Developing people
for health and
healthcare

THE NHS CONSTITUTION
the NHS belongs to us all

Contents

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Foreword *by Sir Keith Pearson*

NHS Staff and Learners' Mental Wellbeing Commission Chair

The NHS is founded on a common set of principles and values that bind together the communities and people it serves - patients and public - and the staff who work for it. If we are caring and compassionate, then we should be able to demonstrate those values as employers in the way we look after our employees.

We must be able as employers to underpin those values with interventions and support that are available to all staff for their wellbeing needs. If someone is looking to join the NHS, whether through education and training, an apprenticeship or direct employment, they should be able to see and feel that the health service is a *wellbeing employer* and is bringing to life the statements expressed in the NHS Constitution.

It is an opportune time to be looking at the NHS as an employer and as a place where people learn by committing to this Commission. In 2018 we celebrated the 70th anniversary of our National Health Service. Back in the 1940s as service personnel returned from the Second World War there was a widespread feeling of altruism that there needed to be a reward for the huge sacrifice of lives lost. The NHS was that 'prize'. Today the NHS is a much larger and more complex organisation, but it is still a people-led health service. Seven decades on, we rightly celebrate the NHS and its achievements but must now recognise where we could do better as employers. We must put considerable energy and effort behind making sure that when we celebrate NHS 75 there is a recognisable improvement in the way we look after the wellbeing of our learners and workforce.

One in four people in the UK will experience a mental health problem in any given year and mental health problems are one of the main causes of the burden of disease worldwide. We should be concerned about the incidence of mental ill health in our schools, colleges, universities and the general workforce, not to mention the healthcare workplace. This NHS Staff and Learners' Mental Wellbeing Commission (the Commission) has sought out evidence on causes, interventions, innovations and good practice that will shape a healthier future for all as part of Health Education England's health and care workforce strategy.

The NHS Long Term Plan, published January 2019, sets the challenge of establishing a new deal for staff, which would see a modern working culture where all staff feel supported and respected for the valuable work they do. The Plan aims to build an NHS where: *"the values we seek to achieve for our patients - kindness, compassion, professionalism - are the same values we demonstrate towards one another."* This chimes with the views of the Commission and we feel this vision is embodied within our recommendations. The Long Term Plan wants to see the NHS become: *"a consistently great place to work,"* where there is more flexible working, enhanced wellbeing and career development, and greater efforts to stamp out the scourge of discrimination, violence, bullying and harassment. This again resonates with the themes and recommendations of our Commission. With this shared agenda, we anticipate being able to advance a range of measures that will support staff and learners' mental wellbeing through the working groups implementing the Long Term Plan.

Such measures will also build a more attractive and welcoming workplace in which people of all ages can launch their careers. It is clear that our school pupils and young people who go on to take clinical courses at university are a very different group of people to the generations before.

Known as the 'millennials' or 'Generation Y', and now being followed by 'Generation Z', this demographic appears to be more open about emotions than the generations before. They are said to be motivated by different factors to their older peers and this is evident in our schools, colleges, universities and the NHS workplace.

This Commission has heard about how managers and leaders working in what is a four-generation NHS workforce should 'learn' how to get the best out of colleagues who are at the beginning of their professional careers. Our young people seek workplace flexibility and the ability to react to new opportunities, yet in healthcare we provide the most rigid training programmes possible. If students on clinical undergraduate courses decide for whatever reasons that their chosen career path in a health profession is not for them, they must be able to exit the system with dignity. Better still, the NHS should be doing more in partnership with schools and colleges to better explain A level (or equivalent) subject combinations that lead to clearer apprenticeship, university and career choices that might result in jobs and careers in the NHS. One in two staff working in the NHS today will still be in the workforce in 15 years' time. More than half a million of our future workforce are still pupils in education today. They are for the most part, bright and deeply caring. Many will become the next

generation of nurses, doctors, health scientists and therapists providing healthcare to the people of this country.

It is hard to imagine the 13-year-old, currently consumed with schoolwork, emerging from medical school in ten years' time as a doctor. These same teenagers are already expressing concerns about the weight of expectation placed upon them by parents, their teachers and their school. They feel burdened by this expectation, knowing that 'under performance' is often viewed by their school as a target missed, a benchmark moved and a failure to be explained. Teenagers talk openly about feeling 'stressed' and increasingly are seeking support from their school *pastoral* (or wellbeing) care service, the child and adolescent mental health service, their GP, online support and their peers. Stress appears now to be the norm for teenage years and beyond, and it is these same stressed teenagers who we are trying to entice into higher education and apprenticeships to become our future workforce. Stress can be a positive and expectation can be helpful, but both should be balanced with realism.

Many of these teenagers will have done well, very well - through their school years, 'A streaming' through GCSEs and A Levels; the teachers will be happy, the school will be delighted, and the student and parent will rejoice at getting

the university of choice. But who has prepared the teenager to recognise that their fellow students are almost all 'A streamers'? Not all can come first so some will struggle and might experience 'failure' in their exams for the first time, possibly 'failing' at something for the first time in their lives. At all stages of the academic and professional career there are transitions, as there are throughout life. How do we best support our school pupils, undergraduates, postgraduates and those progressing through the early stages of their careers to transition from one phase to another? How are we caring for their health and wellbeing as they make the steps? What support is in place when those steps are 'mis-placed'?

While mental health is more openly talked about; for many pupils, undergraduates, postgraduate trainees, and NHS staff, their mental ill health is kept from even the closest of friends and their family. Mental ill health can express itself in many ways, and in the most tragic of cases, we discover that the individual has taken their own life. Evidence presented to the Commission appears to show that deaths by suicide among doctors in recent years are reducing but in other professions, including female nurses, the figures are increasing. Regardless of rate trends, behind every statistic is an individual person, a grieving family and friends. One death by suicide in our workforce or among those who are learning in the NHS is one too many.

There are 1.4 million people in the NHS workforce. We deploy many of our people to frontline healthcare and we should want to be an exemplar when it comes to the support of these people. There is sufficient evidence which shows the NHS can do much better.

This Commission has looked at what we are doing currently, where there is excellence and where we could aspire to excellence. As a result, a series of recommendations have been developed. The arm's-length bodies of the Department of Health and Social Care should work with other key stakeholders to determine who will lead on each of these. Where there are still gaps in our knowledge we have stated where more evidence and insight are needed.

Sir Keith Pearson JP DL
NHS Staff and Learners' Mental Wellbeing Commission Chair

NHS Constitution for England [1]

We strive to improve health and well-being and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it - in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Our mental health environment

1.4 million workforce in the NHS

NHS currently celebrating its **70th** anniversary

Half of lifetime mental ill health, excluding dementia, starts by the age of **14**

One in 10 children and young people have a clinically significant mental health disorder and/or emotional and behaviour problems

Suicide is one of the **three** most common causes of death in young people - and is rising in 15-19 year olds

Approximately **25% to 35%** of young people requiring mental health or wellbeing support are not accessing services

The cost of poor mental health in the NHS workforce equates to **£1,794 - £2,174** per employee per year

Three-quarters of mental health problems are established by the age of **24**

The rates of depression among training grade doctors has been estimated at about **30%**

Top **four** factors which affect mental wellbeing (according to Student Minds): fear of being judged, stress, finding the confidence to tell people you have a mental health problem, and facing stigma that 'mental health problems are seen as a weakness'

A survey of **3,500** doctors showed that **73%** would choose to disclose mental ill health to family or friends rather than a healthcare professional

One in three of the NHS workforce have felt unwell due to work-related stress and one in two staff members have attended work despite feeling unwell because they felt pressure from their manager, colleagues or themselves

Ending stigma - compared to ten years ago students entering higher education are now **five** times more likely to disclose a mental health condition

The return on investment in work-place mental health interventions is **£4.20** for every **£1** spent

1. Introduction

1.1 Our aims

This NHS Staff and Learners' Mental Wellbeing Commission has set out to discover and review evidence of good practice where the mental health and wellbeing of staff and learners in NHS organisations has been made an organisational priority. HEE recognises its central role in supporting the current and future workforce to deliver high quality, safe care and the Commission has examined successful interventions from around the country, to identify what has worked well and what could be adopted widely. Our aim is to see an NHS where staff and learners are happy and feel fulfilled in their work, where they look forward to going to work and are proud of the care they provide to their patients. There is good evidence that happy staff are more compassionate and provide safer care.

1.2 About the Commission

The Health Education England (HEE) draft Health and Care Workforce Strategy for England to 2027 - *Facing the Facts, Shaping the Future*[2] - announced a new Commission on the mental wellbeing of NHS staff and learners. The Commission has been led by Sir Keith Pearson, former Chair of Health Education England, and Professor Simon Gregory, Director and Dean of Education and Quality, Midlands and East, as Programme Clinical Director.

HEE clinical fellows undertook an extensive literature review, supported by the HEE Kent, Surrey, Sussex Libraries and Knowledge Services team, and provided invaluable clinical influence on the main chapters in this report with support from colleagues in and outside the organisation.

An interim report was presented to the Secretary of State for Health and Social Care in summer 2018, and this final report builds on the literature review and research findings of that interim report working with a Commission panel of subject advisors and experts meeting during summer and autumn 2018.

The panel heard from staff working in the NHS whose wellbeing has been adversely affected by workplace experiences, and we heard from several families bereaved by the death of a loved one who ended their life while in the employment of the NHS.

The Commission also heard from representatives of beacons of best practice where colleague wellbeing is supported and championed. In addition, visits took place nationwide to find out more about how organisations are valuing, supporting and caring for their staff and for learners on undergraduate clinical education placements or receiving postgraduate training. We are grateful to everyone who has given up their time and provided valuable contributions. This final report, written to support the new long-term NHS Plan, has been produced for the consideration of the Secretary of State for Health and Social Care and thereafter for publication.

1.3 Our key lines of enquiry

This Commission has examined the culture of learning for individuals, from schooldays, through further and higher education and onto advancing their professional careers in the health and care workplace. Each of these stages or transition points is captured in chapters two to five of this report. We have considered various societal factors, pressure points and specific challenges at all stages of their educational and career progression. Throughout this journey, we have identified five key lines of enquiry which have influenced our approach. Our key cross-cutting questions are:

NHS and higher education culture, climate, context and myths

- What aspects of the NHS or university culture might have an impact upon mental wellbeing?
- Are individuals reluctant to make their mental ill health known?
- Do individuals fear that disclosure might have a detrimental impact upon their success or career?
- What might help dispel myths and misconceptions about mental ill health?
- What can be done to support mental wellbeing of all in the NHS and ensure that we identify ongoing support and interventions, and do not focus solely on the most acute problems

Isolation and lack of support

- What are the challenges for learners who move away from their home area to access education

and training, working at a distance from family and friends?

- What support is in place for learners both clinically and for their personal wellbeing?
- Could this support be improved or delivered differently?

High expectations on learners

- Many of our learners will be high academic achievers. On entering clinical training they may find the continued high expectations challenging. What could better prepare learners for this at all stages of the transition?
- What should be put in place to help learners cope with the high demands of their future clinical career roles?

Societal changes

- How do changes affecting the role of healthcare professionals over recent decades impact upon learners?
- What changes in societal expectations and behaviours are having an impact upon the experiences of our learners?
- What should we be putting in place to prepare and support learners with respect to societal changes?

Generational changes

- What are the challenges that learners face in relation to changing perceptions and expectations of lifestyle, careers and working life?
- What do we need to do differently to take account of these changes?
- How do we best manage situations where those teaching and supervising these learners may be from a different generation with differing views?
- What impact on our learners' experience will the exponential rise in availability and capability of technology, including social media, have?
- How can we make best use of technology and social media to improve the learner experience and support wellbeing?

1.4 Mental health and wellbeing terminology

A report such as this gives us an opportunity to consider the appropriate terminology used in describing the concepts of mental health and wellbeing. Mental health is defined by the World Health Organisation (WHO)[3] as: *'A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'*

The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: *'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.'*

It is our view that the mental health of learners and staff in the NHS should be viewed as a continuum just as there is a continuum in a person's physical health. As Rethink Mental Illness state[4]: *'Mental health is something we all have, and it's something that changes at different times in our lives. We all have a body and we all have a brain, so we all have physical health and mental health. Some people think of their mental health as 'emotional health' or 'wellbeing'.'* It is unfortunate that the term 'mental health' may have negative connotations among some people, perhaps because they connect it to 'mental illness'. However, when we talk about 'physical health' we do not automatically think of illness - associations tend to be much more positive.

Dr Stan Kutcher[5] has written about various mental health states, saying that mental disorders can: *'… exist concurrently with mental wellbeing. None of the domains are exclusory to the other domains at one time and a person can be in more than one domain at the same time. For example, a student can have a mental disorder (such as ADHD), be experiencing a mental health problem (such as the death of a grandparent), be experiencing mental distress (such as an imminent examination); and be in a state of mental equilibrium (such as spending time playing a game with their friends).'*

There are various terms used to describe states of poor mental health. The Mental Health Foundation[6] talks of people with mental health problems, people with experience of mental and emotional distress, and people with a mental illness. In this report we have tended to use the term 'mental ill health'.

Whichever term someone in society choses to use, we are keen to see an end to any stigma around the specific words 'mental health'. *We all have mental health as we do physical health. We strive for mental wellbeing.*

In this report, we have tended to use the term 'mental wellbeing' to describe a state of being that is not only free of mental ill health but encompasses a broader context of social, emotional and physical wellness. Mind[7] defines this stating: *'Mental wellbeing describes your mental state - how you are feeling and how well you can cope with day-to-day life. Our mental wellbeing is dynamic. It can change from moment to moment, day to day, month to month or year to year.'* The Government Office for Science (2008)[8] described mental wellbeing as a: *'dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.'* As an employer the NHS needs to ensure that its managers and leaders are as alert and responsive to this as they would be to physical wellbeing.

This change in focus of terminology is vital for staff, learners and employers as we switch the focus from negative connotations to a culture and environment that supports wellbeing. It should be remembered that in our many encounters in practices, clinics, wards and departments we find that the majority of NHS staff are happy, contented and fulfilled and that staff, students and postgraduate trainees are going above and beyond to deliver the best care in often difficult circumstances.

1.5 Our key themes

For the benefit of those reading this report, we have picked out some key themes and discussions that have emerged during the course of the Commission.

- **Preparing for transitions** - a constant theme throughout has been the importance of transitions, as an individual progresses through school (chapter two) towards further or

higher education (chapters three and four) and eventually into the workplace (chapter five). It is important how we prepare individuals for the big changes to come in their lives

- **Diverse needs** - the difficulty of making life transitions can be exacerbated for many reasons including socio-economic background, cultural diversity or disability - these challenges need our particular attention

- **Need for self-care** - if a person is intolerant of their own distress, they may not be able to tolerate the distress of others. We need to support a learning and workplace culture which encourages compassion to oneself, where self-care is 'normalised'

- **Being human beings** - some clinicians may feel a need to adopt a 'superhero complex' to help deal with the pressure of their role, but we need to acknowledge in healthcare that being a human being and high performing are not mutually exclusive

- **Caring for the carers** - the Commission has considered the question: 'who cares for the people who care for the nation?' We must improve the way in which we look after ourselves and our colleagues, so they are better placed to look after the needs of their patients

- **Moral distress** - the NHS attracts people of a caring nature but where institutional constraints compromise perceptions of the level of care offered, our staff can develop a sense of personal guilt

- **Bereavement by exposure** - every clinician carries with them a lifetime experience of upset, trauma, death and dying; professionals working in healthcare have very different emotional and psychological needs to those working in other sectors

- **Bereavement by suicide** - has been shown an identifiable factor for self-harm, and suicide for those who have a close connection with the deceased. We have heard that this could well apply to clinical and educational colleagues,

not least due to the often devastating effect of colleague suicide and the guilt many health professionals feel about colleagues' death

- **Looking after loved ones** - healthcare practitioners do not work in isolation in the world - we need to consider how their wellbeing at work is affected by and affects family and friends/colleagues, particularly in the most tragic cases where people are bereaved by suicide

- **Take a break** - often under pressure from colleagues or the accepted workplace culture, staff can feel pressurised to work long shifts without breaks, come to work when ill (presenteeism) and even skip annual leave, particularly where staffing is under-resourced

- **The simple things** - wellbeing at work needs to be addressed strategically across the NHS but often it is the simple things in the workplace that can make a real difference: staff lockers, showers, a quiet room, the availability of nutritious food, a good coffee, a psychologically safe space to get together with others to talk and debrief, or just a colleague taking the time to say 'thank you'

- **Role of technology** - technology has been put forward as both the likely cause and possible solution to some wellbeing issues - we need to consider more the role of tech gadgets and social media.
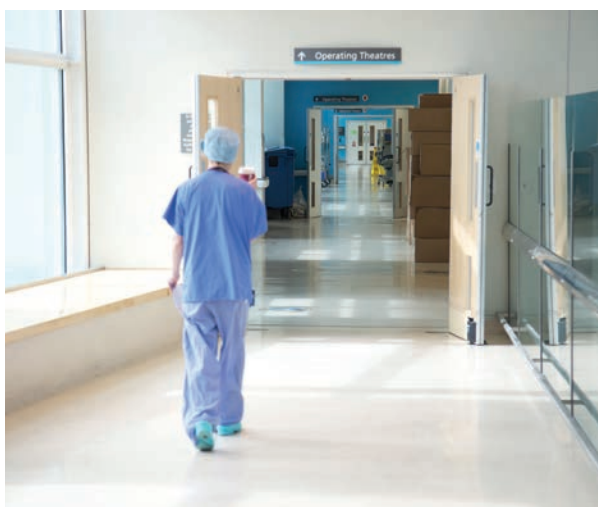
1.6 Our approach

This Commission was charged with addressing both staff and learner mental wellbeing. To do so, we have divided our consideration into four key chapters. These are:

Chapter 2. Learning our lessons - here we briefly consider the mental wellbeing of young people and in particular their routes into the NHS workforce and what the NHS needs to understand about them and offer to them.

We then subdivide learners into undergraduate students and postgraduate learners.

Chapter 3. Lessening student stress - the mental wellbeing of undergraduates who are learning in the NHS is a key issue for this Commission with the majority of such students based in educational institutions but placed in multiple healthcare settings.

Chapter 4. Mastering mental wellbeing - postgraduate learners are both trainees and employees. This leads to significant overlap with the issues for undergraduate learners, yet these postgraduate learners are also NHS staff. We have therefore, focused on the mental wellbeing of postgraduate learners in the NHS as a separate chapter. While this includes postgraduate medical trainees about whom much is known there are many other postgraduate learners included in this category including nurses, psychologists and healthcare scientists.

Chapter 5. Supporting our staff - there are 1.4 million people in the NHS workforce across clinical and non-clinical careers ranging from porters to engineers, from chief executives to cleaners, all are vital to good running of the NHS and to high quality service. The NHS employment culture is key to supporting these staff and therefore here we focus on mental wellbeing of the workforce.

Throughout these chapters we have found common themes and much overlap. We have sought to minimise duplication but we encourage consideration of the findings and recommendations in all chapters.

We have broadly categorised the 33 recommendations into three groups that address the NHS culture, the mental wellbeing of NHS staff and those learning in the NHS, and the support the NHS provides to them.

The recommendations in this report are grouped under the following headings but we appreciate that some might fall under more than one category:

- NHS culture - recommendations:
  1, 2, 12, 15, 16, 17, 18, 20, 21, 23, 27, 33

- Staff wellbeing - recommendations:
  7, 8, 13, 14, 22, 24, 25, 26, 30

- NHS support to staff and learners - recommendations:
  3, 4, 5, 6, 9, 10, 11, 19, 28, 29, 31, 32

1.7 Online engagement

We say later in this report that for the most part, people enter healthcare employment because they want to care and heal or because they simply like working with people. Work is good for us and the vast majority of people who come to work in the NHS every day do so because they love their job, they enjoy the people they work with and take great pride in knowing they are there to help and support patients, carers and families. This was reflected in an online survey carried out for the Commission and it was encouraging to have received confirmation that some respondents reported good, progressive and supportive workplace wellbeing initiatives. However, early findings from the Commission's online engagement show that only 40% of our clinical staff (48% for learners) reported that their wellbeing at work was good, and 76% reported having experienced mental distress or ill health. For our non-clinical workforce respondents, the figures were similar, with 46% reporting good wellbeing at work and 72% having experienced mental ill health or distress. Over a quarter of respondents felt that their wellbeing was 'not important' to the NHS.

We found that 60% of our clinical staff reported missing meals at work on at least a weekly basis over the last six weeks, compared with 38%

of non-clinical staff and 35% of postgraduate trainees. While working patterns have changed over recent years with larger numbers of the non-NHS workforce choosing not to take lunch breaks (reportedly 35% of office workers regularly do not take lunch breaks), the opportunity to access food, and provision of an appropriate environment in which to eat, must be of paramount importance and the NHS should be a model employer.

Of particular concern, 40% of our postgraduate learners and one-third of clinical and non-clinical staff did not feel able to disclose mental ill health or distress to line managers or peers. This suggests an unknown level of mental distress among our workforce that we must address. Over 45% of clinical, non-clinical and postgraduate respondents to the online engagement identified that their wellbeing is best supported by their peers. In this case, we need to ensure that we are providing appropriate resources to staff to enable them to support colleagues.

This online engagement has provided a new dimension of feedback from staff and those learning in the NHS that is not currently captured through other mechanisms such as the NHS staff survey. It gives sufficient new insights that we have agreed with NHS Employers that they will look further at the results including the free text comments and to consider whether engagement such as this should be conducted further in the future.

1.8 Investing in wellbeing

At a time when the NHS is struggling to balance the books, it would be easy to question if now is the time to 'invest' in wellbeing for staff and those learning in the NHS. But if we question the cost of investment in wellbeing let us not overlook the cost of not doing so.

Set out here are examples of the costs that could be reasonably reduced if the recommendations in this report are given sufficient priority:

- NHS sickness absence rates are reported to be at least 4.5% per annum and estimated to cost £1.1 billion. The NHS Long Term Plan workforce workstream has set the ambition to reduce this by 1% (to 3.5%) by 2020. If this releases savings

in the same proportion as current estimated costs, then savings could exceed £120m

• In so far as staff retention is concerned, 350,000 people left the NHS for reasons other than age retirement over the past five years with leaver rates rising from 5.7% in 2012-13 to 6.7% in 2017-18. The additional cost of this deterioration in retention is considered to be as much as £100m per annum

• Work-life balance is reported as a factor in 13% of NHS leavers (45,000 people over five years)

• If working lives were extended by a year this could over time represent a supply boost of between 3% and 5% (assuming average service of 20-30 years with breaks) with perhaps £30 million in avoided agency costs over five years.

1.9 Wellbeing

"I worked several times on very traumatic jobs involving children. After I had my own children, I think the relation between the job and the personal life was what really took me over the edge, and I started feeling things that I have never felt before … Talking was really important, but even that wasn't quite enough for one particular incident for me."

HRH Prince William, quoted in the media[9], speaking at the *This Can Happen* conference in London,

2018, which aims to tackle mental health issues in the workplace. The Duke of Cambridge served as a pilot at the East Anglian Air Ambulance and worked alongside doctors and paramedics providing emergency medical cover in eastern England.

This report references the importance of promoting and supporting the wellbeing of NHS staff and those learning in NHS settings. We will say that working and learning in the healthcare sector is like no other employment environment. Daily, our staff are confronted with the extremes of joy, sadness and despair. We repeatedly heard that this emotional labour is often exhausting. The Commission heard described how many of our clinical staff retain a collection of curated traumatic memories of death and dying. Many of our staff, often young staff, see the horrors of extreme trauma; they see the aftermath of major road traffic accidents, suicide, and they see children in distress or dying and they help families cope with the loss of a loved one. They see the effects of deprivation and many see, what they described to us as 'life in the raw'. These memories, like ghosts from the past may return at unexpected times. The emotional labour required to manage this rollercoaster for NHS staff and those learning in the NHS is often taken for granted by the individual and by the NHS itself, but the Commission found that there are dangers to this which can profoundly impact upon the wellbeing of staff and those who are learning in the NHS.

Recommendation 1:
The NHS Workforce Wellbeing Guardian

As we have reviewed the academic literature and taken evidence, it has become clear that as in many other non-healthcare sectors there is a need for board-level leadership to be responsible for the mental wellbeing of their staff.

The evidence for board-level leadership is in the following chapters but the role is so central to all the recommendations in this report, in particular the culture of the NHS, that our primary recommendation is the creation of board-level NHS Workforce Wellbeing Guardians.

Therefore, the first recommendation of the Commission is the introduction of this role in every local, regional and national NHS organisation. We anticipate this board-level role being an existing executive director who would be aligned with a non-executive director. The NHS Workforce Wellbeing Guardian will seek to assure and continue to re-assure the board that their organisation is a wellbeing organisation and a healthy workplace in which NHS staff and learners can work and thrive. The role will ensure that sufficient information is being provided to the Board, so it can benchmark, set organisational expectations and monitor performance in this regard. This will help provide a lens on learner and staff mental wellbeing in each and every NHS organisation, seeking continual improvements in how those who care for the nation's health are indeed cared for themselves and supported in their working lives.

The ways in which the NHS Workforce Wellbeing Guardian will work would be for determination by the individual organisation but should be within a common NHS framework, allowing for local best practice in supporting learner and staff mental wellbeing. However, it is envisaged that at an organisational level, the Workforce Wellbeing Guardian will be aligned with a Workplace Wellbeing Leader.

It is recommended that the NHS should establish an NHS Workforce Wellbeing Guardian in every NHS organisation (where appropriate such as primary care this may be at a locality level) and that the Wellbeing Guardian should be authorised to operate within the nine principles set out on the following page:

The NHS Workforce Wellbeing Guardian Principles:

Principle One: *The mental health and wellbeing of NHS staff and those learning in the NHS should not be compromised by the work they do for the NHS.*

Principle Two: *The Wellbeing Guardian will ensure that where there is an individual or team exposure to a clinical event that is particularly distressing, time is made available to check the wellbeing impact on those NHS staff and learners.*

Principle Three: *The Wellbeing Guardian will ensure that wellbeing 'check-in' meetings will be provided to all new staff on appointment and to all learners on placement in the NHS as outlined in the Commission recommendations.*

Principle Four: *All NHS staff and those learning in the NHS will have ready access to a self-referral, proactive and confidential occupational health service that promotes and protects wellbeing.*

Principle Five: *The death by suicide of any member of staff or a learner working in an NHS organisation will be independently examined and the findings reported through the Wellbeing Guardian to the board.*

Principle Six: *The NHS will ensure that all staff and learners have an environment that is both safe and supportive of their mental wellbeing.*

Principle Seven: *The NHS will ensure that the cultural and spiritual needs of its staff and those learning in the NHS are protected and will ensure equitable and appropriate wellbeing support for overseas staff and learners who are working in the NHS.*

Principle Eight: *The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010.*

Principle Nine: *The Wellbeing Guardian, working with system leaders and regulators, will ensure that wellbeing is given equal weight in organisational performance assessment.*

Recommendation 2:
The NHS Workplace Wellbeing Leader

The ability to address staff and learner wellbeing issues that may be either, 'critical' at first contact, or may 'slowly' be contributing to an unhealthy culture would be dependent upon hearing from staff at their level. Such contact would need to be conducted in a manner that was supportive and did not pose a risk to the individual(s). This requirement indicates that there must be an active 'listening' component and to this end, a Workplace Wellbeing Leader is envisaged for all NHS workplaces.

It is recommended all NHS organisations appoint a Workplace Wellbeing Leader to work with and report to the Workforce Wellbeing Guardian.

In early 2019 consideration will be given to the guidelines for both of these roles.

2. Learning our lessons
The mental wellbeing of young people

2.1 About this chapter

For the most part, our future nurses, allied health professionals, scientists, doctors, dentists, pharmacists and the wider healthcare workforce, are currently doing their SATs, GCSEs and A levels (or equivalent). We know that school age children begin to forge views about what kind of person they are developing into, where their strengths lay, their evolving personality and the academic subjects they enjoy at an early stage in their school life. Certainly, by the age of 11 or 12 years, pupils are narrowing down their possible broad areas of interest and how this might influence their choice of subjects to be taken at a later stage.

The modern NHS is one which recruits for values and trains for skills, and therefore, we need to be playing our part in ensuring that pupils, schools and parents have access to the most up-to-date information about the NHS, careers in the NHS and where entry routes into healthcare can offer a variety of alternatives. It is timely that Health Education England has recently launched a new online guide to health service careers - www.healthcareers.nhs.uk/FindYourCareer

As the NHS is likely to be the largest employer in many communities, we have a legitimate concern for the education and mental wellbeing of young people, many of whom will soon be advancing their learning or stepping into the NHS workplace. The starting point for considering the future mental wellbeing of our health service staff and those learning in the NHS is therefore, not in our universities or hospitals but it is with school pupils in their classrooms and in their homes. It is here that the next generation of healthcare professionals will have spent their formative years, gaining academic, personal and life skills. It is also here that the effect of life's expectations starts and where its first impact upon their mental wellbeing can be found.

> **"**
>
> *As a society, we are very good at helping our young people talk about mental health - we are, however, less good at helping them to know what to do about it.*
>
> Professor Louis Appleby, lead for the National Suicide Prevention Strategy for England, personal communication

> **"**
>
> *It is easier to build strong children, than to repair broken men.*
>
> Frederick Douglass, 1817-95, an African-American statesman

2.2 Key Questions

In this report section we are seeking to answer four key questions relating to the mental wellbeing of secondary school-age pupils who may be considering entry routes into a future career in the NHS:

1. What are the risk factors (personal, family, social, societal and educational) for mental ill health in adolescents?
2. What early factors associated with planning for a future career in healthcare may affect an individual's mental wellbeing?
3. How can we best support the transition of future healthcare professionals from school or college to apprenticeships, further education, higher education and beyond?
4. What can we learn from the evidence base that enables schools and colleges to better support pupils, improving the mental wellbeing of adolescents planning for careers in the NHS?

2.3 Mental wellbeing of young people

Mental wellbeing is integral to human health and happiness. The positive consequences of improving children and young people's mental wellbeing are numerous, but encompass better cognitive development and learning, physical and mental health, and social and economic prospects in adulthood.[10]

Young people with better mental wellbeing recover more quickly from illness, are less likely to engage in behaviours which may put their health at risk and appear to cope better with stressful events.[11] Conversely, young people with mental ill health are at increased risk in later life of issues including poor educational attainment, anti-social behaviour, and drug and alcohol misuse.[12]

In the UK research literature, we have found that:[13]

- Half of lifetime mental ill health starts by the age of 14 years
- One in 10 children and young people have a mental health disorder and/or emotional and behaviour problems
- One in seven children and young people have

less severe problems that interfere with their development and learning
- One in 25 children are affected by anxiety and depression
- Suicide is one of the three most common causes of death in young people - and is rising. Suicide is the biggest killer of young people aged 20 to 34 years
- Adolescent self-harm and eating disorders are a growing problem
- Approximately 25% to 35% of young people requiring mental health or wellbeing support are not accessing services, and
- 60% to 70% of children do not receive appropriate interventions at a sufficiently early age.

These issues do not seem to be confined to the UK, an important factor as the NHS has a multi-national workforce. Bodies such as WHO are increasing global awareness of the unacceptably high incidence of youth mental health problems, although there is still much work to be done.[14]

Adolescence is a period of transition that poses a risk to mental wellbeing. Growing up involves often unpredictable emotional and physical transitions that are stressful for all young people.[15]

Even routine and predictable processes such as progressing through school and college years can prove challenging.[16] Adolescence brings hormonal shifts that result in emotional, intellectual and physical changes - these changes can influence and challenge the senses of self, identity and relationships.

2.4 Support in schools and colleges

As well as striving to support their pupils' and students' wellbeing, career decisions and transition to employment or further study, schools and colleges are embarked on a major series of changes to the courses and qualifications that they offer. Some are already well underway, such as the reform of GCE A Levels, bringing back two-year programmes, with final written examinations as the norm, rather than the modular structure, with significant coursework and an intermediate AS Level, that was introduced in 2000-01. A radically

new approach to technical, professional and vocational education is also beginning, following a major review led by Lord Sainsbury and embodied in the Government's *Skills Plan*. This will introduce technical study programmes - now called T Levels, that are equivalent to, but different from A Levels and from general vocational programmes such as BTEC. The first three T Levels will be available from September 2020, in digital, construction, and education and childcare, with the remainder from 2023, and all will have a substantial mandatory work placement.

This creates an opportunity for the NHS to become more proactively and systematically involved with schools and colleges and to open up the enormous range of opportunities that the NHS offers for students undecided about their future career intentions. The Government's new *Careers Strategy* specifically calls for employers to: "Provide encounters that inspire people and give them the opportunity to learn about what work is like and what it takes to be successful in the workforce," and the NHS is well-placed to be a prime mover in doing so.

2.5 Risk factors for mental ill health

There are many risk factors which appear to be associated with mental ill health in adolescence. The WHO and Calouste Gulbenkian Foundation (2014) have identified these as including factors such as parenting, household (including income, housing and employment), community and neighbourhood safety, availability of education and health services, and national factors such as poverty reduction, inequality and discrimination.[17]

The lasting effects of adverse childhood experiences affect the current and future NHS workforce not only through the interactions they have with patients who may have suffered these events, but also a proportion of staff who may have themselves been directly affected in childhood. While the psychological scars and suffering of childhood may enable healthcare professionals to be more empathic with their patients, they may also increase the risk of compassion fatigue and burnout.

The relationship between social media and young people's mental health is still to be fully understood and is rapidly changing. There is a generation-defining change in its availability, use and acceptance. There is also a perceived dichotomy between its negative impact and the potential for support and engagement. However, the NHS needs to recognise that the workforce entering higher education today has not known a world without the internet and social media and should recognise that it is an important part of the lives of the current and future workforce.

2.6 Numeracy and literacy

A consideration that is emerging for pupils considering health careers is their education in, and attainment of, literacy and numeracy skills. Figures show that in the adult population nine million people in England struggle with basic quantitative reasoning or have difficulty with simple written information.[18]

There are illuminating reports regarding the numeracy of some newly qualified health service staff. NHS staff surveys reveal that more than half of the health and social care workforce experience workplace stress, some even consider resigning from their work, due to their difficulties coping with the expected level of numeracy. The lack of learning of these core skills at school has a direct impact upon people's subsequent self-confidence at work, their ability to work safely and efficiently in their roles, and on career progression. Poor numeracy deters people from applying to, and accessing, some careers in healthcare, and is associated with high levels of rejection at interview for a number of healthcare jobs. These factors all affect personal mental wellbeing.[19] Recommendations have been made through 'Skills for Health' reports that the health sector should connect with those creating short and long-term national policy and undertake action to improve skills in basic English and maths.[20]

It is essential that all learners and staff have the numeracy and literacy skills required to both learn and to deliver safe care. There is much good work in this field including that by National Numeracy and other education institutions to support NHS staff and learners to have the necessary functional skills to do the job asked of them.

2.7 Planning for a future career in healthcare

2.7.1 Access to careers advice

A career in the NHS encompasses huge variety and numerous possibilities. There are approximately 350 different health roles in the NHS including management, leadership, finance and administration, professional services and many more. Knowing what these are and the types of pupils that may be best suited for each of these roles can be confusing for school career professionals let alone their pupils. Often with a lack of dedicated careers staff, schools rely on the sometimes-patchy careers knowledge of teachers.[21] The NHS locally, regionally and nationally should be doing much more with schools and colleges to better explain the routes of entry that will ultimately lead to jobs and careers in the NHS. In the Commission's online engagement, (see section 1.6) only 5% of undergraduate respondents had accessed careers advice through their school or college service, and only 7% had accessed the NHS Health Careers website.[22] The majority (62%) had undertaken internet-based searches themselves to find the guidance they required, with 20% sourcing advice from family members and friends already working in the NHS. Similar responses were given in relation to accessing work placements prior to commencement of training in NHS careers, with only 7% accessing placements through school or college, and 15% sourcing work experience opportunities through family and friends already working within the NHS.

The Commission feels there needs to be awareness and honesty about the personal attributes that are required not only for entry to clinical professional roles but also to sustain and thrive throughout future careers, and that some, despite academic prowess, are simply not suited to careers in healthcare or to the career of their choosing. Some have the grades but not the necessary attitudes and some have the required values and behaviours but have not yet demonstrated academic capability. We need to ensure that careers guidance encourages an honest conversation about careers and routes into those careers which may not always be from A levels to higher education, and that some, however much they seek a career in healthcare, may remain not best suited. Equally there are some schools that have never had a pupil attend medical school. The impact on the social capital of that community cannot be overlooked. HEE can already observe a trend of future healthcare professionals who seek to live and learn locally and when qualified to deploy those skills into the communities they are proud to call home.

The careers landscape - and types of opportunities - within the NHS is constantly evolving. By 2027 it is estimated that approximately 45,000 nursing associates will be in post in the NHS - 17,000 of whom are expected to up-skill to become registered nurses. The defining of a meaningful career path is thought to have triggered a rise in the number of people applying to become healthcare assistants where a career escalator to becoming a registered nurse is now more apparent. Applications and recruitment to medical associate professions, such as surgical care practitioners and physician associates, are similarly likely to increase across the NHS if we invest more in career profiling at all phases of transition. The increasing demand for more flexible careers is set to influence how NHS career paths develop, with the prospect of more clinical professionals choosing a portfolio career in future.

It is important that school pupils and college students get accurate careers guidance, both to inform important life decisions, and to reduce the risk of later career disillusionment and career goal discrepancy, which may be a risk for later mental ill health. Potential NHS career applicants need to be made aware of the benefits and the challenges of working in the NHS. Personalised advice in secondary schools and colleges is essential and can be supported by resources available online such as Health Careers and Step into the NHS.[23]

Several NHS trusts have evolved work-based education teams delivering a range of interactive career session to pupils and students in years nine, ten and 11, colleges and sixth form. These sessions delivered in NHS hospitals - often on weekends - provide taster tours, bespoke tours and specific tours for those considering specific careers (for example nursing or medicine). East Lancashire Hospitals NHS Trust is an exemplar, working across

agencies including the Department for Work and Pensions, the Prince's Trust, Step Into Health and local schools and colleges.

In December 2017 the Government published its careers strategy[24] to build a world class careers system. A key aim is that all young people in secondary school receive a stable, structured programme of advice and guidance delivered by individuals with the right skills and experience. We believe that every school, college and academy providing secondary education should improve their careers provision using the Gatsby Charitable Foundation's Benchmarks which define an excellent careers programme. Good careers guidance should motivate young people and protect their mental wellbeing by giving them a clearer idea of the routes to jobs and careers that they will find engaging and rewarding.

One benchmark is that every pupil should have the opportunity for a personal guidance interview. But to what extent are pupils considering careers in the NHS currently getting appropriate advice and benefiting from revamped careers guidance? Currently schools are struggling to meet the Gatsby Benchmarks. One in five schools are not achieving any benchmarks and on average schools are only meeting 1.87 (out of eight) of the benchmarks. The current NHS careers offer is not sufficient for the needs of today's school pupils. Schools and their pupils need proactive engagement with ready access to work experience and experience of work in the NHS.

2.7.2 Work experience

NHS 'place-based' systems and employers (for example, sustainability and transformation partnerships (STPs), integrated care systems (ICSs), clinical commissioning groups, primary care networks, GP federations/super-practices and provider trusts) working with schools, colleges, further and higher education institutions need to co-ordinate support to deliver local NHS careers advice sessions. This must include, as recommended by the Government's careers strategy: *"…encounters that inspire people and give them the opportunity to learn about what work is like and what it takes to be successful*

in the workforce," and the NHS is well-placed to be a prime mover in doing so. NHS work experience must be for all pupils - not just those with 'connections', this is also key to widening participation in health careers.

There is increasing evidence of learners wishing to live, learn and develop careers locally which the NHS should embrace. This is good for patients, good for communities and good for the NHS staff who serve those communities.

2.7.3 Applying for places

Many young people applying to study in further and higher educational environments may find the process stressful due to the competitive nature of the application process, the often high academic demands, and the perceived 'high stakes'. While these factors are not limited to healthcare careers, the entry requirements for undergraduate programmes leading to NHS employment can be some of the most demanding. 'A streamers' (high-achievers) who are used to being top of the class may find it difficult to adjust to a new scenario in which they are excelled by their peers. For the first time these students may perceive themselves to be 'failing' - a point highlighted in this report's foreword.

If we consider pupils applying to medical school as a case study the dedication required to pursue a career in the NHS becomes apparent. UK applicants to medical school must almost universally achieve academic excellence from GCSE level upwards. Standard entry requirements to study medicine at university are three 'A' grades at A level. Dentistry similarly requires three 'A' grades. Applicants will be expected to have succeeded in some subjects for which they may not have a natural aptitude. Medicine is one of only a few undergraduate courses, along with law and mathematics that mandates an aptitude test as part of the application process. All of this can be a source of anxiety and distress.

Additionally, medical school applicants are expected to be polymaths with a broad range of skills and hobbies and often voluntary activity, but the pressure of work at university can gradually squeeze

such broader activity out. Yet, paradoxically, such activity may well be a protective factor for mental wellbeing.

The Commission is aware of the HEE-funded Youth Sports Trust which has been delivering a pilot programme in schools in the north-west with the aim of creating a youth health ambassador movement within schools. The aim of this is to influence health and wellbeing with their peers and raise awareness of health and social care careers, as well as leading to a qualification in health and wellbeing leadership.

2.8 Specific issues for high-achievers

High-achieving or 'gifted' secondary school pupils confront the same transitions that all encounter as they move to the university. There is however a paucity of literature on this subject. Unsuccessful transitions negatively affect students' academic achievement with accompanying levels of psychological distress.[25]

Gifted students who felt exceptional at school may find the transition particularly difficult as they move into an environment with similar high-achievers. This may vary as to whether they are grouped in high-ability or mixed-ability classes.[26] When required to push themselves academically they are at increased risk of 'hitting the wall' - rooted in the habit of needing to exert minimal effort to achieve the grades they require at school.[27] We should ensure an environment in which we all openly discuss such issues about the pressures on high-achievers and how best to address them.

The NHS needs to value and support of all learners across the academic spectrum of abilities recognising that all have needs.

2.9 Learning our lessons

Adolescence is a period of many, often stressful, transitions which can put a young person's mental wellbeing at risk. Statistical evidence suggests that young people are vulnerable to mental ill health during their later school or college years, and many evidence-based risk factors have been identified that may harm an adolescent's wellbeing.
It is during this 'high-risk' period of life that pupils are asked to: perform to the best of their academic ability - often with life-long consequences if they cannot; make an informed choice about their future career - often with sub-optimal careers guidance; apply to higher education programmes - a long, often opaque process with stringent demands; and prepare for one of their biggest life transitions - being separated from many of their key support structures while developing lifestyle and academic independence as they enter higher education. A young person considering the next steps towards a career in the NHS may be at particular risk due to the academic performance demands and higher educational entry requirements necessary to show their commitment to a perceived life-long career choice.

The challenges facing young people are enormous. It is therefore, unsurprising that many young people appear unready for independence as they enter higher education. A study, carried out by the Higher Education Policy Institute and Unite Students,[28] found that many students are deeply ill-informed about what to expect when they get to university.

The key findings of their *Reality Check* report include:

- 60% of university applicants expect to spend more time in lectures than they do in school lessons - yet only 19% of students find this happens
- Only 37% of applicants with a mental health condition have declared, or intend to declare it, with their prospective university
- While most applicants (62%) believe they have a good grip on money matters, only 43% are confident about paying a bill and only 41% feel they understand student finances, with many under-estimating essential expenses
- Almost half (47%) of all applicants feel unprepared for living with people they have never met before, with gay, lesbian, bisexual and other sexuality applicants less confident about making friends (58%) than heterosexual applicants (74%).

Some of the contributing factors will be societal - some adolescents will have lived through poverty, family disharmony and adverse childhood experiences which may include forms of child abuse. Some factors may relate to over-protection by parents and teachers - we speculate that parents are becoming increasingly protective against milder forms of risk, and teachers are becoming increasingly reluctant to fail pupils. There may also be a generational component with the internet and social media impacting on how young people communicate, form relationships and source information.

Recommendation 3:

Planning for a possible future career in healthcare will start for many pupils prior to taking GCSE exams. It is important therefore, that the NHS is proactive in ensuring that school careers advisors, pupils and parents are as well informed as possible about the NHS, how it works, entry routes into careers and where advice can be found. If pupils are better informed and thus better prepared for their careers, the transition points and the whole decision-making journey will be less stressful and more exciting.

New generations of the future NHS workforce are looking for clear, concise information. They want planned and often different career paths and many will aspire to flexible careers - even career portfolios. But they often experience rigidity in the system resulting in a sense of failure when they later discover they have chosen the 'wrong' A level subjects leading to the wrong course and a sense they have let themselves and others down when compelled to look at a different career direction at the very beginning of their career journey.

The final years of school and the start of a working career in the NHS, either through further education, higher education or apprenticeship are stressful enough, without the added pressure of prior decisions being poorly informed.

Working with schools and colleges, career advisors and current and past pupils, the NHS Careers Service should examine what information about careers in the health and care sectors we provide, the format and medium in which that information is provided and how the NHS can work more effectively in partnership with schools and pupils.

The NHS Careers Service and the wider NHS should where necessary recalibrate the job and career advice currently provided to schools, pupils and parents.

Recommendation 4:

Career pathways should identify potential routes and choices including step-on and step-off points and the potential for up-skilling and future re-skilling including qualification requirement, work experience, traineeships, apprenticeships and direct access following university.

The NHS should publish and update regularly its advice on the flexibility in education and training entry routes and career journeys into NHS careers.

Recommendation 5:

Increasingly, applications to university undergraduate courses in medicine, dental, health sciences, nursing and the allied health professions require evidence that the applicant has explored a career in healthcare prior to an application and that this can be found through some form of work experience in the sector. The Commission has found that it can prove to be difficult if not impossible for some schools and pupils who do not have the 'contacts' in the NHS and care sector to get this experience. Pupils without contacts in the NHS feel disadvantaged if they are unable to evidence in their UCAS application and in a subsequent university interview a significant voluntary placement in the health or care sector. As the largest employer in most towns, the NHS is best placed to proactively offer a 'bureau' service working with local schools and colleges to establish and operate a pupil work experience programme that is easy to access, and responsive to the needs of local schools. This would include co-ordinating voluntary placement opportunities.

Healthcare providers (such as GP practices, hospitals, and care home operators) on a local (STP or ICS) footprint should create a schools' work experience bureau service.

Recommendation 6:

Pupils with learning difficulties, such as dyslexia and dyscalculia, seemed to the Commission to be supported well as they transition through the key stages of education, though we have heard that still more could be done. Many schools have well-developed mechanisms to get the most out of all pupils. Evidence suggests that pupils with learning difficulties who are supported experience little or no overall disadvantage, though such pupils are more likely to become stressed when they consider transition to further or higher education, worrying if the same level of support would be available.

There is no doubt that universities offer considerable support to undergraduates with learning difficulties but more needs to be done. The websites of UCAS, Office for Students and many universities offer helpful guidance to pupils with learning difficulties, but the UCAS website information for pupils with learning difficulties sits under the 'disabled students' tab which may not be helpful.

The Commission recommends that published UCAS and university support and guidance for undergraduates with learning difficulties should be reviewed with schools, colleges and pupils with learning difficulties to ensure it conveys the right and supportive information around this most important transition point.

3. Lessening student stress
The mental wellbeing of healthcare undergraduates

3.1 About this chapter

There are about 125,000 undergraduate nurses, allied health professionals, scientists and medical, dental and pharmacy students at any one time in our universities and colleges. These undergraduates represent the future workforce for the NHS and how we work with them during their clinical placements in the NHS can influence the quality of their education and impact their future decisions about whether to enter the health service workforce.

Undergraduate education places high levels of expectation on the student. It is evident that students undertaking undergraduate clinical courses face different challenges than their peers taking different degrees. Stress and reported mental ill health exist in all undergraduate courses but this chapter will explore how well the further and higher education sectors, along with the NHS as an education partner, work with and support students on health undergraduate courses.

Health is fundamental to how we function in and contribute to society. That is particularly the case for undergraduate students who are at a stage of life where they may be beginning to define what their contribution to society will be. Mental wellbeing and mental ill health can impact a person at every level - study, work, socially, self-care and ability to thrive in their environment.[29]

Student Minds, a UK student mental health charity, has identified a significant number of challenges which can affect student mental wellbeing. The top four are fear of being judged, stress, finding the confidence to tell people you have mental ill health or are struggling, and facing the stigma that 'mental health problems are seen as a weakness'.[30]

As we focus on healthcare students, we know that individuals who experience mental ill health can experience a severe impact on their ability to thrive,[31] leading to depression, burnout and in the most tragic cases, suicide.

University should be a place where healthcare students thrive, develop empathy and build resilience, as they gain the skills and knowledge to become a part of the future NHS workforce.

Healthcare professionals lacking empathy can ultimately impact the care provided to patients. This must be addressed, for the benefit of students in training, the future workforce and our patients.

Stigma about mental ill health is slowly being eroded in society.[31] Compared to ten years ago students entering higher education are now five times more likely to disclose a mental health condition.[31] However, evidence suggests there remains significant under-reporting from healthcare undergraduates who have not disclosed mental health conditions or mental ill health, have not accessed any help and often fear the consequences of doing so.

Three-quarters of mental health conditions are established by the age of 24.[32] As mental ill health has increased in our student population, demand for support services has soared.[33] The Prince's Trust has reported that young people's happiness and confidence are at their lowest recorded levels.[32]

The Institute for Public Policy Research (IPPR) has reported that young adults today are more likely to experience mental ill health than previous generations.[31] The IPPR has also found higher rates of mental ill health among students than those of the same age not attending university. This presents a significant opportunity to improve the mental wellbeing of the general population by addressing the issues faced by undergraduates and improving service provision for students.

3.2 Key questions

Our key questions for the mental wellbeing of undergraduate learners are:

• What are the risk factors that contribute to mental ill health in undergraduate learners, and what additional risks are particular to healthcare students?
• What are the barriers or perceived barriers that healthcare students face in accessing appropriate support?
• How can we best support healthcare learners throughout their undergraduate years and enable them to become thriving practitioners?

3.3 Risk factors for all students

3.3.1 The transition to higher education - a high risk period?

"All pupils who proceed to university are confronted with demands that are of such magnitude that they may be conceptualised as a quantum leap rather than a transition." [27]

"Entering university requires multiple complex transitions for a student - all happening together. This is a significant time of change in a person's life and can be a cause of substantial stress." [34]

For some students pre-existing conditions may be exacerbated during this time, for others the stressors can trigger mental ill health.[34] In so many ways students, at a pivotal stage in their lives, are moving from the familiar to the unknown.[35,36] This takes place in their personal circumstances (often moving to a new home in a new city, adapting to a new educational system) and in relationships (forming new relationships with students, peers, academic staff and university support services while maintaining existing family and friend relationships). During this process, appropriate support should be available and accessible, and the level of support adjusted for any individual based on their specific needs at any point in time.[37]

3.3.2 Living arrangements

There is a clear connection between where we live and health. Our accommodation and those whom we live with can contribute positively or negatively to our health. In a report by Student Minds on student living arrangements,[29] a series of recommendations are made, addressing factors such as student accommodation (university and private sector), community building, peer support and social networks. Healthcare students often have added stressors in this regard due to clinical placements that require either travel or temporary relocation.

3.3.3 Social pressure

During transition into and out of university there are numerous social pressures faced by students. These include leaving behind old friendships including close friends they may have known for most of their school years; developing new friendship groups in a busy and confusing unfamiliar setting; a desire for social acceptance, and possibly an increased exposure to drugs and alcohol. Some students who struggle with the type of issues outlined above may come to be seen as different and isolated.

Loneliness has been identified by students as a significant challenge to their mental wellbeing (Student Minds, 2014). Social media and internet use also play a role although more research is needed. One study among medical, dentistry and pharmacy students showed an association between internet addictions and insomnia, stress, anxiety, depression and low self-esteem.[38] However, for some, social media can provide positive emotional support with academic problems and the sharing of stressful clinical experiences. It has been suggested that this may help develop personal and group resilience for these students.[39] For most young people their smart phone provides instant access to social and community (peer) support as well as for information. In a healthcare setting it may not be possible to access, thus cutting off for some a sense of community, belonging and social support.

Struggling to cope with social pressures can mean the university experience fails to live up to the expectation that it will be 'the best time of your life'. In some cases, this may contribute to the emotions that lead to suicidal thoughts and ultimately suicide itself. To enable better response and prevention, more robust data of student mental health is needed, as well as a greater understanding of student suicide.[40] Suicide prevention and activities which reduce risk and promote healing after a suicide death are required in university and health care settings. A good example of a toolkit for workplaces has been produced by Business in the Community, which partnered with Public Health England (PHE) and the Samaritans, helping organisations support the mental and physical health and wellbeing of employees (*see Useful Resources*).

3.3.4 Financial pressure

Financial pressure plays a part in mental health at undergraduate level for many students. For many, this may be the first time they have needed to budget their expenditure and manage their costs, and this can be a daunting experience. Many undergraduates will face the competing pressures of splitting their time between their studies and earning an income, nothing that is new in higher education but nonetheless a poorly understood aspect of university life. For those on nursing and allied health professional courses, the removal of the training bursary and the introduction of student loans in 2017 has added to the financial pressures these students face at university. This is particularly the case for mature students who will have settled lives, possibly children, and fixed financial commitments at home to manage. As medical training is longer than other courses, this can result in additional financial pressure.[41]

The Commission heard from the bereaved family of an undergraduate nursing student who took her own life. The family told the Commission that alongside her university studies and 12-hour clinical placements in the NHS, she found it necessary to take two other jobs *"…to be able to earn money to feed herself."* The Commission was reminded that unlike other students on non-nursing courses, undergraduate nursing students are required to complete about half their undergraduate studies 'working' in the NHS, unpaid and that this seriously limits the time available to take up a part-time job as other students might do. Travel to and from clinical placements places another challenge on nursing and allied health professional students. For some students there will be a requirement to take up additional accommodation on such clinical placements where this is some distance from the university or private accommodation in their university community (*see section 3.5 on 'challenges'*).

3.3.5 Influence of age

International research has shown a greater vulnerability among mature nursing students for 'home-college conflicts'.[42] Traditionally, nursing undergraduate courses in the UK have attracted many mature students, people who will have had a career but whose values have drawn them to the profession. Entering higher education as a mature student can be daunting, particularly if the last formal education setting was ten or 20 years ago as is often the case. Mature students have traditionally done well, despite the challenges of 'learning to learn' again and, once qualified and registered, have entered the NHS and progressed quickly into supervisory and managerial roles. Every effort must be made by the higher education sector, social care and the NHS to attract these mature students; to support their mental wellbeing; to recalibrate expectations when unavoidable home-college conflicts arise and to help them through the journey of learning once again.

3.3.6 Additional demographic factors

Cultural background, gender and sexual orientation (among other factors) have an impact on mental wellbeing. It is known that non-heterosexual students,[43] females[31,44] and those from a less wealthy background are at greater risk of experiencing mental ill health.[34] In addition, the UK is the second most popular destination for international students[31] which poses cultural, language and communication differences that impact on student mental wellbeing. Individuals studying here from other countries may lack information on how UK care services work, despite

the best efforts of universities, or may feel unable to access support because of their cultural stigma.[31 32]

Universities must create an environment which supports equality and diversity. An independent review carried out by Cardiff University's medical school into issues of racial equality found several race specific issues and students of black, Asian and minority ethnic (BAME) backgrounds had complained of being unsupported appropriately. The panel made recommendations to improve internal procedures related to diversity and equality following the review.

Non-UK university applicants are less likely than UK applicants to declare pre-existing mental health conditions. Similarly, applicants from poorer backgrounds are least likely to disclose their condition, possibly due to greater stigma in these groups. Indeed, there may be an 'inverse care law' at play here where possibly, those from better off backgrounds are more likely to seek help, have a diagnosis and therefore have something to knowingly disclose. On the other hand, gay or lesbian students are more likely to disclose a mental health condition. The IPPR report shows that students are unlikely to disclose if they think they are likely to experience prejudice or if their future career may be jeopardised.[31] These are areas that we feel worthy of further research and consideration.

3.4 Widening participation

Changes to educational policy have emphasised the concept of widening participation and providing lifelong opportunity for groups previously under-represented in higher education and professional careers. This includes encouraging students from socio-economic groups three to five; people with disabilities; and people from specific ethnic minorities to undertake courses designed for future healthcare careers. Widening participation should also include supporting entry of those with long-term conditions and those for whom English is an additional language. The NHS workforce needs to better reflect the communities that it serves and to be inclusive of and supportive of those who seek to learn and work in health care.

Widening participation has increased student numbers and increased student diversity. An increased level of first year withdrawal from undergraduate programmes has been seen in the 'widening participation' demographic, despite recent research suggesting that the academic performance of medical students educated in the worst performing secondary schools matches, if not betters those from top schools.[45] Issues raised include the importance of social and academic integration, the mismatch between student expectations and experiences, lack of appropriate academic study skills and the importance of student support. Concerns reported include the relative impersonality of the staff-student relationship in university and the emphasis on self-direct learning.

Research has identified the 'importance of self' concept and personal support systems as a factor in students continuing into the second year of undergraduate study. Evidence supports the value of activities which promote social and academic integration early in the transitioning student's experience.[46,47] Furthermore, research suggests altering the school environment and teaching methods to better mirror higher education may be an effective strategy.[48,49]

3.5 Challenges for healthcare students

International and UK research focusing on medical students[50,51,52,53] shows that they can experience higher levels of anxiety, depression, burnout and personal distress compared to age-matched, cross-sectional controls. There are several factors for this, including high workload, long hours, navigating ethical conflicts and managing the emotional requirements of the role. Nursing students are reported to experience high levels of stress due to aggravating factors which stem from the intensity of academic programme and clinical performance.[54]

Over the course of a three-year nursing degree programme, the undergraduate has historically been expected to accumulate a total of 4,600 hours of learning, of which 2,300 hours is theory and 2,300 hours of clinical practice. Unlike their peers who have embarked on other degree courses, the nursing student will work clinical placements at night, over weekends and bank holidays.

Much of the research on factors which influence mental wellbeing has been focused on nursing and medical students. There is less literature and insight into other healthcare students. As there are common factors in the various NHS workplaces and clinical placements, we suggest many of the challenges facing healthcare students can be generalised.

3.5.1 Culture

In medical schools, many cases of mental ill health remain under-reported.[50] Stigma surrounding mental health problems[31] significantly hinders medical students from seeking help[41,55] where a concern for the consequences of disclosure continue to be seen as an obstacle.[53] One reason repeatedly cited internationally by medical students for this is what they describe as the 'toxic' culture of healthcare - which includes elements of fear and shame.

The Student Minds report showed that students in general fear being judged if they disclose their mental ill health and seek help, concerned about the consequences of disclosure for their career prospects. This is discouraging some students from accessing the help they vitally need and in the most tragic cases, may contribute to circumstances when students take their own life. While society has improved in talking about mental ill health, the higher education sector and NHS has more to do if they are to create the supportive environment that enables students to feel comfortable in disclosing their mental ill health.

The current NHS workforce can do more to promote an acceptance that everyone has a continuum of mental health. We know that some doctors self-manage and self-treat.[41] Students learn from what they see modelled - bad behaviour promotes bad behaviour, intolerance promotes intolerance - and so the cycle of stigma moves to the next generation. A lack of openness and recognition by senior clinicians and managers in the workplace around mental ill health retains a sense of stigma and hinders a much-needed culture change. This serves only to preserve the unhealthy and unnecessary silent endurance of those learners who need help.[56]

To continue the battle against stigma, we need to question the readiness of current educators, supervisors and academics to lead the way in normalising and esteeming mental health alongside physical health. Staff need to be equipped in how to share their own difficulties in a safe, supported and beneficial way. Unless we see a radical shift in the stigma associated with mental health, fear will hinder learners from seeking help[55] and will discourage them from engaging with proactive and preventative strategies for mental wellbeing.

There are four generation groups working in the NHS.[57] One study, on nursing and midwifery in the UK, revealed stark differences in the key values and motivations of the current early career workforce compared with previous generations. 'Generation Z' (born between 1995 and 2010), for example, do not want to be 'forced to fit' into a traditional work environment. For 'Generation Y' or 'millennials' (born between 1980 and 1994) workplace culture is important and they will look to work in an environment which boasts a strong team culture. These generations are now all working together in the NHS. We need to ensure that we develop a workforce that is able to deal equally with clinical and organisational demands and is supported in so doing.

As employers, the NHS must resist the temptation to dilute the enthusiasm of our next generation of clinical professionals. We should not drag this enthusiastic, values-driven group into our world of pressures, targets and deliverables. We must tempt them into a world that values and welcomes their energy, their new and fresh perspective on life and work, and their refreshingly open, accepting and generously inclusive views.

HEE is doing much to support the younger generations, not least with the development of the *Modern Firm,* the Annual Review of Competence Progression (ARCP) review and *Enhancing Junior Doctors Working Lives* - these need to be used as tools to support healthy environments. While in the main these are aimed at postgraduate doctors, there are key elements that apply to all and should apply to all. These initiatives have been well received by learners and educators alike.

Case Study:

Creating a learning culture
School for Nursing and Midwifery, Birmingham City University

As highlighted in the RePAIR report,[58] the School for Nursing and Midwifery at Birmingham City University obtained permission to modify the NHS Culture of Care Barometer, to help the School understand more about the academic environment in which the students learn. This approach has enabled staff to openly report how they are feeling about their work culture and what is important to them. It has enabled a deeper understanding of both strengths and areas of challenge. The learning from this initiative informs the School's annual development strategy. Future plans include an annual review of the culture of care in the School. The other schools within the faculty are also planning to adopt this approach. Furthermore, discussions are underway with clinical colleagues regarding use of the Culture of Care Barometer to develop a greater understanding of the culture in the students' clinical learning environment.

3.5.2 Placements in the NHS

For the majority of undergraduates on healthcare-related courses, the NHS is an education partner delivering work-based education and training. During their placement the NHS will also be supervising students. The relationship between the NHS, the university and the student is a partnership and when this works well, the beneficiary is the student and ultimately the NHS where most graduating students will deploy their newly acquired skills in delivering patient care.

"At the university you get taught all this theory as a student but then you go out onto placement and it's quite disheartening at times. I have even been asked 'why am I so nice?' I will listen to the patient story and I intend to treat people how I would want to be treated."

Trainee nurse who spoke to the Commission

Many seek careers in the NHS based upon positive experiences of care and care givers. It is essential that clinical placements, particularly first clinical placements are a similarly positive experience. However strong an individual's vocation is, it can be lost if their experience is dissonant with their values, aspirations and chosen career.

In October 2018 HEE launched a report and a set of resources aimed at supporting higher education providers and the NHS in reducing the level of student attrition from health-related university courses. The *Reducing Pre-registration Attrition and Improving Retention* (RePAIR) report recommends what should be done system-wide to improve retention.[58] One of RePAIR's key messages was the consistent capture of evidence on the importance of the NHS clinical component of the course to students. The student experience, their desire to stay on the course, or indeed to consider applying to work in a service, is heavily influenced by the clinical supervisor (or mentor) and the culture in that clinical setting. In this context we can see parallels with the education sector where there are reports of one-third of teachers leaving the profession in their first five years - a rate seemingly lessened by well-targeted support, carefully matching the mentor and new teacher.[59]

Learners told the Commission that they learn most from inspirational near peers and excellent role models. Thus, experiences in healthcare need to be underpinned by excellent clinical placements with well-trained and supported, inspirational, values-driven, caring, compassionate and supportive educators.

The Commission heard accounts from many pre-registration student nurses of the positive impact a mentor can have on a student.

"When a mentor has confidence in you, it builds your confidence in your ability to become that nurse you want to be."

A second-year children's nursing student, London.

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

A second-year adult nursing student, London.

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

A second-year children's nursing student, Midlands and East.

HEE's Quality Framework, (*see Figure One*) supports and assures high quality clinical learning environments and is a tool that could be used to assure the environment for the wider-workforce.

A good NHS placement should provide an opportunity for the learner to experience the NHS as a wellbeing organisation. The learner should experience good team dynamics and positive role modelling. They should be able to witness and contribute to the delivery of safe, effective,

kind and compassionate patient care and thereby develop good patient care and caring interactions with patient, carers and families. The Commission would expect the Workforce Wellbeing Guardian (recommendation one) to provide evidence to the Board that learning in their NHS organisation is a positive and developmental experience.

Healthcare students face the added pressure of balancing academic deadlines with a clinical placement responsibility, which brings a unique set of stressors.[53] Clinical placements can be a time of excitement, where theory meets practice and the reality of being a physiotherapist, paramedic, pharmacist or nurse associate becomes a lived experience. It is the time when our future clinical workforce meets the current workforce and it is the time when they also meet patients, families and carers. Though this can be a truly exciting time for students, there are many factors which

can negatively impact on their mental wellbeing when possibly the weight of expectation is at its highest. The Commission heard how the experience of a clinical placement can be markedly different between different NHS organisations and between different clinical placements within the same NHS trust. We heard how a poor clinical placement can be so defining that it leads to students exiting their course. However, we equally heard that a good clinical placement embraces not just the teaching and learning but can offer insights into the NHS as an employer; as an employer where staff wellbeing is important and as a future employer that cares for its people. We also heard that the students quickly form a self-supporting community in the university setting and in this regard, they value clinical placements where they continue to learn together and provide support for each other - we feel this should be encouraged where practical.
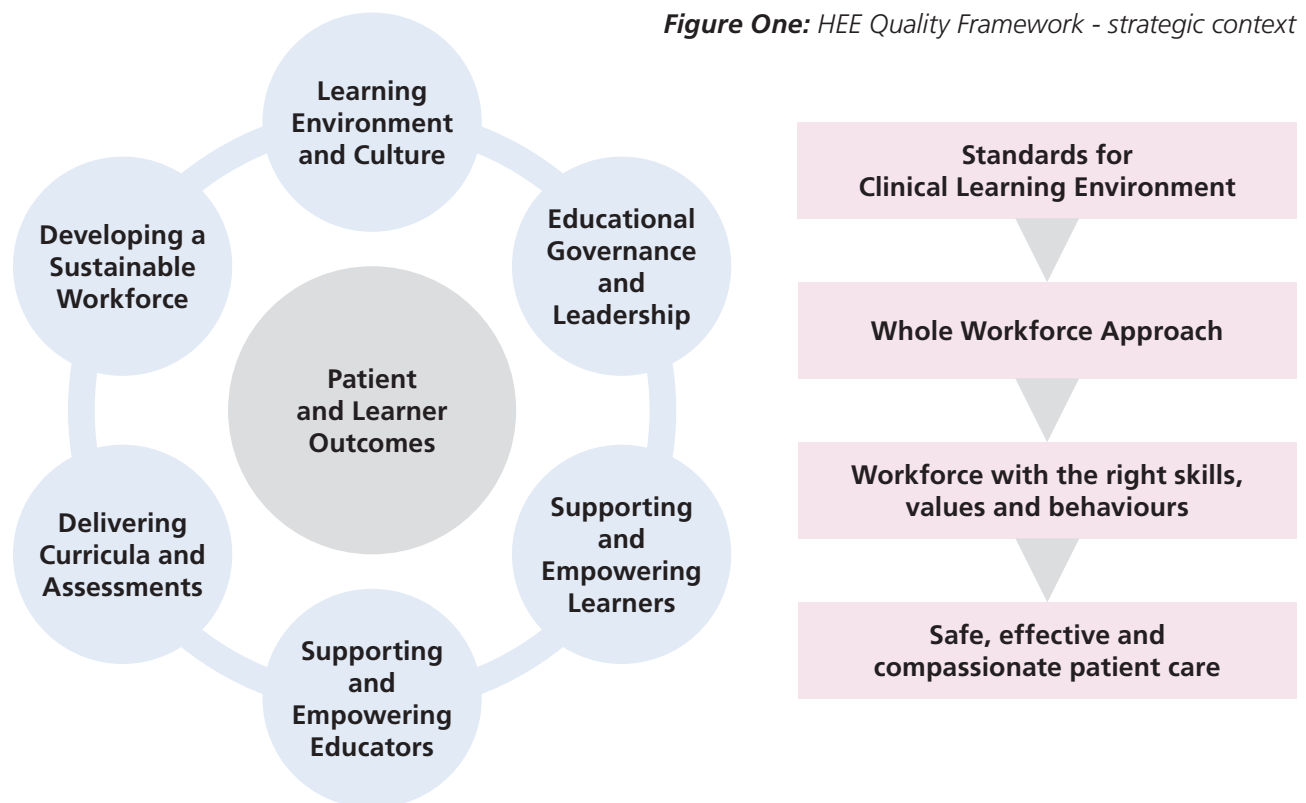
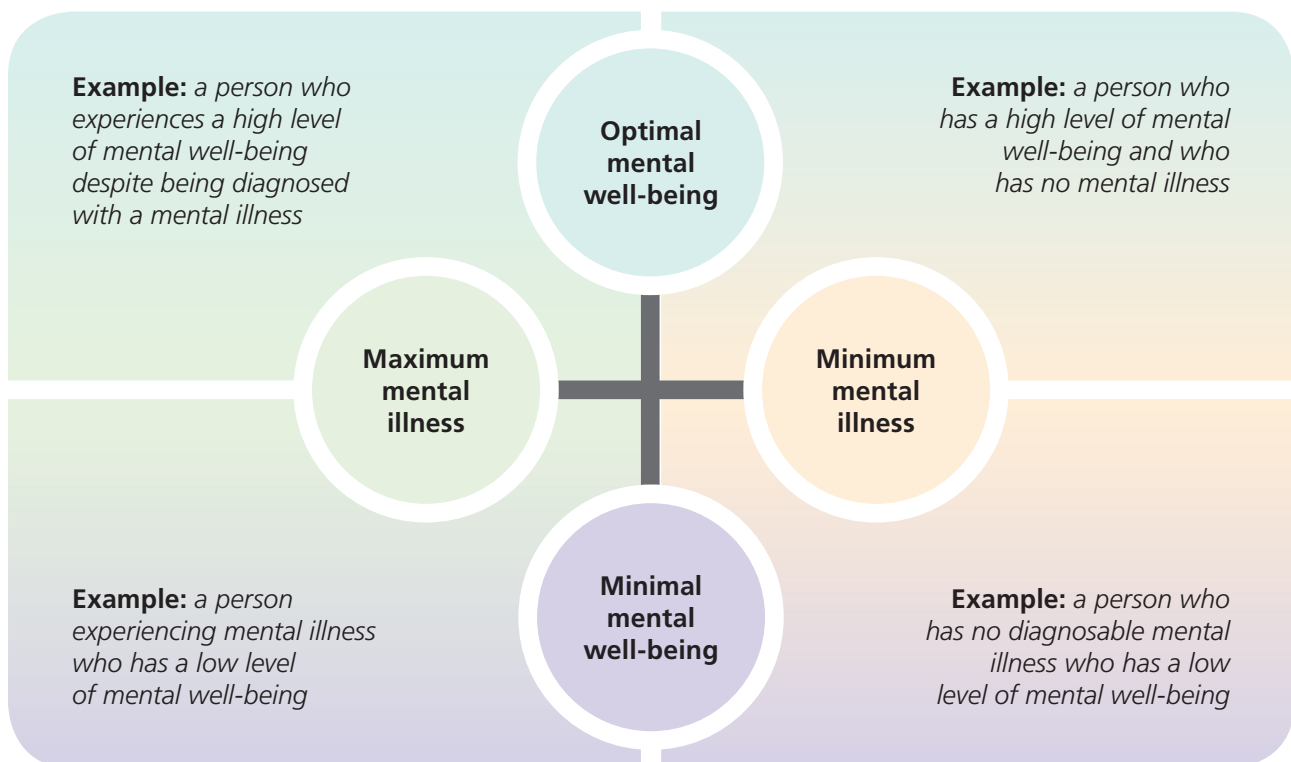*Figure One:* HEE Quality Framework - strategic context

Experiencing a certain amount of nervousness and apprehension while on clinical placement is normal and to be expected. However, if anxiety is not appropriately managed, it can contribute to increased distress and ultimately increased attrition rates,[60] something that is an international problem especially in nursing education programmes.[61] Attrition from undergraduate courses can have serious consequences for workforce planning for professional groups already understaffed in the NHS.

Student placements vary in duration which can make integration with clinical teams a challenge, and lead to learners feeling isolated and unsupported. This can be a particular problem for the millennial's view of workplace culture as they strive to achieve specific clinical competencies.[62] Clinical placements may also require night shifts, where students can experience poorer healthy food choices, fewer chances to exercise and being away from their usual support system. It should be said that the Commission heard consistently from those learning in the NHS and from NHS staff that access to a good healthy food offering in a modern and uplifting 'retail' setting was very important.

Additionally, students face on a daily basis the emotional reality of healthcare which can be distressing as they are exposed to patient suffering, often for the first time, and they experience the moral distress of decision-making or ethical dilemmas.[63] Students can suddenly find themselves facing a myriad of emotional triggers they may not feel equipped to manage. There is also the potential for students to bring with them unresolved psychological and emotional experiences from their childhood. If left unresolved, these may trigger mental ill health throughout the course.

Figure Two: *The continuum of mental health and wellbeing*
(Source: Keyes, c.c.m; (2005) Mental Illness and/or mental health? Investigating axioms of the complete state of mental health. Journal of Consulting and Clinical Psychology. (Vol 73, No 3: 539-548)

Example: *a person who experiences a high level of mental well-being despite being diagnosed with a mental illness*

Optimal mental well-being

Example: *a person who has a high level of mental well-being and who has no mental illness*

Maximum mental illness

Minimum mental illness

Example: *a person experiencing mental illness who has a low level of mental well-being*

Minimal mental well-being

Example: *a person who has no diagnosable mental illness who has a low level of mental well-being*

**Opening up discussions
about mental wellbeing**
The Open Minds programme
at University College London

The Commission heard from Open Minds,
a peer-led mental health literacy
programme in universities and secondary
schools. It was established at University
College London with three aims: to reduce
the stigma surrounding mental illness; to
get young people talking more openly
about their mental health, and to increase
help-seeking behaviour among young
people. To this end, every year a group of
first year medical students are given a short
course on mental illnesses delivered by
psychiatrists and a training-to-teach course
delivered by the medical school. This equips
the students to go into secondary schools
to deliver workshops on mental health to
school students.

Using feedback received over the
programme's 10 years, Open Minds has
found that the initiative has significantly
improved the knowledge and confidence
of the school pupils on this topic. It may
be that future programmes like could
contribute to improved mental health
literacy in future generations of university
and school students.[64]

3.6 Improving support

University is a unique place where work, leisure,
health and social care are provided in the same
setting. This can be the perfect opportunity for
embedding positive mental wellbeing in our
healthcare undergraduate students. In September
2017, the Universities UK framework '#stepchange'
encouraged all universities to make mental health a
strategic priority. Many, perhaps according to some
reports the majority of higher education institutions,
promote mental health initiatives on their campuses.
These enable access to prevention programmes -
some of these being university-wide initiatives and
some for specific clinical student groups. However,
there is clear evidence that there is insufficient
coverage in course content on the promotion of
mental wellbeing and the importance of self-care in
building resilience.

There are obstacles which students have identified
as hindering access to help. These cover difficulties
in knowing what support is available and/or how
to access it. Some students may be aware of
the support but are unsure if it applies to them,
suggesting confusion in communications. Students
have repeated concerns about confidentially, the
impact of disclosure on their future careers, how
disclosure will be managed and where sensitive data
will be stored and managed.[31,41] Universities need to
create greater openness and transparency in their
systems for providing support and provide suitable
assurances about disclosure.

There are blurred boundaries between the roles
and responsibilities of those who teach, assess and
provide personal support. One solution could be the
Nursing and Midwifery Council's (2018) *Standards
for Student Supervision and Assessment.* These
standards are set to see the separation of the role of
teacher and assessor, reducing conflict of interest.

Academic staff might be alerted to the fact that a
problem exists, but they may not be equipped to
manage the problem. Equally, clinical mentors and
supervisors may be responsible for assessing the
placement performance of a student, with a lack
of clarity over confidential support. This raises a
challenge to placement providers and universities
to ensure they have strong links and clarity on roles

and responsibilities, to maximise transparency and offer support where needed.

Various national reports have placed a strong emphasis on a 'whole system' approach to student mental wellbeing, stressing that good mental health will not be achieved without collaboration and effective co-ordination of care between NHS primary and specialist care, and university support services.[32] The Universities UK report, *Minding our Future,* highlights system issues surrounding mental health services for students and outlines how the whole system should work together.[32] This guidance is aimed at improving the co-ordination of care between the NHS and universities so that undergraduate learners can access the care they need. The mental health needs of students must be clearly understood and services re-designed to integrate university support with NHS care more effectively. The guidance calls for solutions to be co-produced, so it is not a case of doing 'to' students but doing 'with'. Student mental health needs should feature as a shared priority in STPs and ICSs. The Commission fully supports the proposal from Universities UK to gain consent from students at the commencement of their programme to contact a named individual in times of crisis.

The Commission offers a word of caution to universities with undergraduates on healthcare courses. While a 'whole system' approach to student mental health will likely work for most students, those who will ultimately undertake clinical placements in the healthcare setting will face quite different personal and emotional challenges. As we say in chapter five, working in the healthcare sector is like no other employment environment. Daily, our staff are confronted with the extremes of joy, sadness and sometimes despair and we say that this emotional labour is often exhausting.

There is progress in improving services and support to students but there is scope for much more to be done. There are significant opportunities for greater collaboration between the university and healthcare systems. This is particularly the case for mental ill health risk factors that can potentially impact all students and healthcare-specific challenges. It is only through a greater awareness

and appreciation of these factors, coupled with a continued and authentic culture change within our healthcare system, that we will see a more holistic and effective approach to mental wellbeing for our students.

It is important that the development and provision of services takes place within a broader commitment to developing as a healthy and health-enhancing organisation. Healthy Universities is one application of the healthy settings approach. This moves beyond the delivery of targeted health promotion programmes in organisational and place-based settings to consider how the contexts in which people live their lives can themselves support wellbeing by embedding health into their ethos, structures and processes.[65,66,67,68] The UK Healthy Universities Network[69] has a membership representing 75 UK higher education institutions with a further 27 UK stakeholder organisations and 23 non-UK universities as associate members.

The Commission notes that the *Information Sharing and Suicide Prevention Consensus Statement,*[70] published January 2014 by the Department of Health in partnership with a number of national professional representative bodies, was agreed but has not changed practice. The Consensus Statement aims to encourage information sharing with families when someone is seen as at risk.

Further work is required with universities, placement providers and students regarding sensitive transfer of information, but such transfer is vital, enabling continuity or transfer of support services. In addition, the transfer of information upon graduation should be further addressed. This may be via a 'passport' that is controlled by the learner and that in a crisis could be shared by others, but this would need to be justified. It could also, where an e-portfolio is used, be in a protected 'locked' area where access must be justified.

All professional regulators should work together with the proposed NHS Workforce Wellbeing Guardian to determine the requirements of this information sharing to address concerns of the professions regarding confidentiality and to ensure such sharing of information is protected for the safety of learners and professionals.

3.6.1 Producing a thriving clinical practitioner

There are many interventions, strategies and tactics available, from support groups to phone apps, to maintain and support mental wellbeing. Research shows that the majority of UK medical schools have implemented self-care training which suggests it is believed to be a good support for student mental wellbeing. However, there is wide disparity among the medical schools and training is only available to up to 10% of students through selected modules.[71]

The link between doctors' wellbeing and patient outcomes has been evidenced by research, supporting that doctors who are self-caring are more able to care for others.[55] The prevailing NHS culture does not always equip medical students to approach the role in the healthiest way.

Healthcare professionals care for patients before they care for themselves. That is also what we teach undergraduate healthcare students, perhaps subliminally or through modelling behaviour. However, leading professionals suggest that putting others before oneself is a myth that needs busting, arguing that we can only care for our patients to the degree to which we care for ourselves. Not knowing how to care for oneself can result in mental ill health, which does not help patient care. While literature is lacking for other healthcare undergraduates, we suggest these principles would generally apply.

Self-care requires self-awareness,[72] which is shown in much of the literature. Being aware of the early signs of mental ill health requires an understanding of what they are. If issues of mental health are not widely understood among students, they may not recognise deterioration.[30] Some students may require greater insight on how they can look after their personal mental health and learn skills for long-term management of negative emotions, stress, anxiety and pre-existing long-term mental health conditions.

Healthcare training has historically placed great emphasis on technical knowledge and clinical skills, but there is limited training in patient compassion.[72] Nursing research suggests that it may be through 'awareness work' that compassion and empathy can be cultivated towards patients and self, although there is not a substantial evidence base that training for empathy may increase insight. While theoretically appealing, it is not clear if it is evidenced or theoretically predicted. Although some evidence suggests that this could positively enhance learners' coping techniques,[73] reducing anxiety and stress and improving wellbeing. Self-care and self-awareness training should be fit for purpose to provide students with the skills and strategies they need to maintain their own health and wellbeing.

If personal support was built into healthcare curricula, it would give greater gravitas to the importance of this subject matter.

The Commission has learnt of examples where personal support is being embedded into course content in medical schools throughout the country. Anglia Ruskin University School of Medicine students have access to a counselling and wellbeing support programme that can be completed on a modular basis. Workshops are held on topics such as mental health first aid, dealing with a crisis, and mood management. Students have the option to self-refer to a counsellor for further support if needed. Embedded within their course, students are also provided with tools to develop more flexible patterns of thinking and behaviour through a 'positive programme' which is designed to unpack behavioural science. The school intends to monitor students' transition to university life through an engagement dashboard. This tool will check key learning activities such as attendance and library use, which could provide an early warning if students are struggling.

Hull York Medical School has developed a central electronic record for students that includes information about mental ill health, student support approaches, disabilities, adjustments, expressions of concern, occupational health support, student support plans and fitness to practise/case management issues. This may be one way to ensure that students are clearly informed about where and when they can seek support and help, before hitting a crisis.

Such approaches could support mental wellbeing, not only as undergraduates but throughout careers, helping keep clinicians healthy and effective, working in the NHS until the age of retirement. Taking this further, we can see how patient care could improve from clinicians better equipped at caring for themselves.[74]

In terms of universal wellbeing conversations, a template tool has been adapted from person centred-planning.[75] It produces a personal profile of preferences that give insight and promote self-awareness for the individual completing the profile. It helps others to adjust behaviour and develop successful working relationships. The personal profile gives a prompt for wellbeing conversations which can begin when there is not an existing problem, helping to establish and support effective relationships. However, the profile can also be reviewed and discussed if a problem begins to emerge. Profiles can also aid peer-to-peer relationships by facilitating conversations on how best to support each other and work effectively together. The creation of personal profiles could be facilitated in a learner environment and if supported in the workplace could support transition into the workplace facilitating opening wellbeing conversations.

The Commission intends that for all new staff and learners a 'wellbeing check-in' would include general support to own wellbeing and signposting to support if self or others later require support. It would be expected that a general check-in of staff and learner wellbeing would become an expected part of staff conversations and appraisals in order that such caring conversations become a normal part of NHS culture. Where increased risk or vulnerability is identified, such as within paramedics and trauma teams who are more likely to be exposed to traumatic incidents, this could be planned for.

Where individuals have specific mental wellbeing needs, personal support planning would be required. There are good examples of this being widely used in social work, domestic abuse, in mental health and suicide prevention, and in health and safety.

3.6.2 Peer caring, coping and resilience

In addition to examining the environment in which our learners and NHS staff work, there are a range of personal support interventions such as peer support. One study shows three out of four individuals who experienced mental health ill health while at university had disclosed this to another student.[76] Benefits of peer support (both informal such as from friendship groups and formal peer support, such as 'nightline'-type support services) extend to the individual receiving the support, those giving the support and for society.[76] Peer support programmes may help to reduce isolation, improve a sense of belonging and effectively support students' mental wellbeing.[76] Peer caring should be encouraged by educators to improve students' subjective wellbeing.[77] Peer support may have economic benefits - utilising the expertise of peers could release capacity for professional services to focus on complex needs. There are opportunities for peer support and discussion of shared experience in placements.[41]

The *Medics4Medics* student-run group within University College London Medical School aims to support the mental wellbeing of medical students. The group runs fortnightly events featuring a talk and group discussion on topics such as perfectionism, supporting friends experiencing difficulties, and being a medical student/doctor with a mental illness. The school also benefits from a peer navigator scheme which can help signpost medical students experiencing mental ill health to sources of support.

Mindfulness as another stress management strategy has been researched internationally. In many cases, practising mindfulness has been shown to decrease stress and anxiety for nursing students while on clinical placements, and assist with academic study.[78,79] Mindfulness-based stress reduction programmes have been shown to reduce anxiety and support empathy in graduate healthcare students.[72] One study of mindfulness training for students in podiatric medicine, occupational therapy, physical therapy, physician assistant and nursing found it may help prevent distress, particularly when students faced clinical placements and academic work.[72]

Simulation has many benefits for learners and ultimately patients. Among these are significant benefits for team training, understanding team dynamics, how to work across professional boundaries and situational awareness. They are particularly useful to provide safe places to make and learn from errors, to discuss and receive feedback and to practise honest and open communication underpinning *The Freedom to Speak Up.* Such interventions have been shown to reduce anxiety among student nurses.[80] Simulation has been shown to increase self-confidence of clinical decision-making.[81]

It is our view that intervention strategies are an area which would benefit from further multi-professional research in the UK.
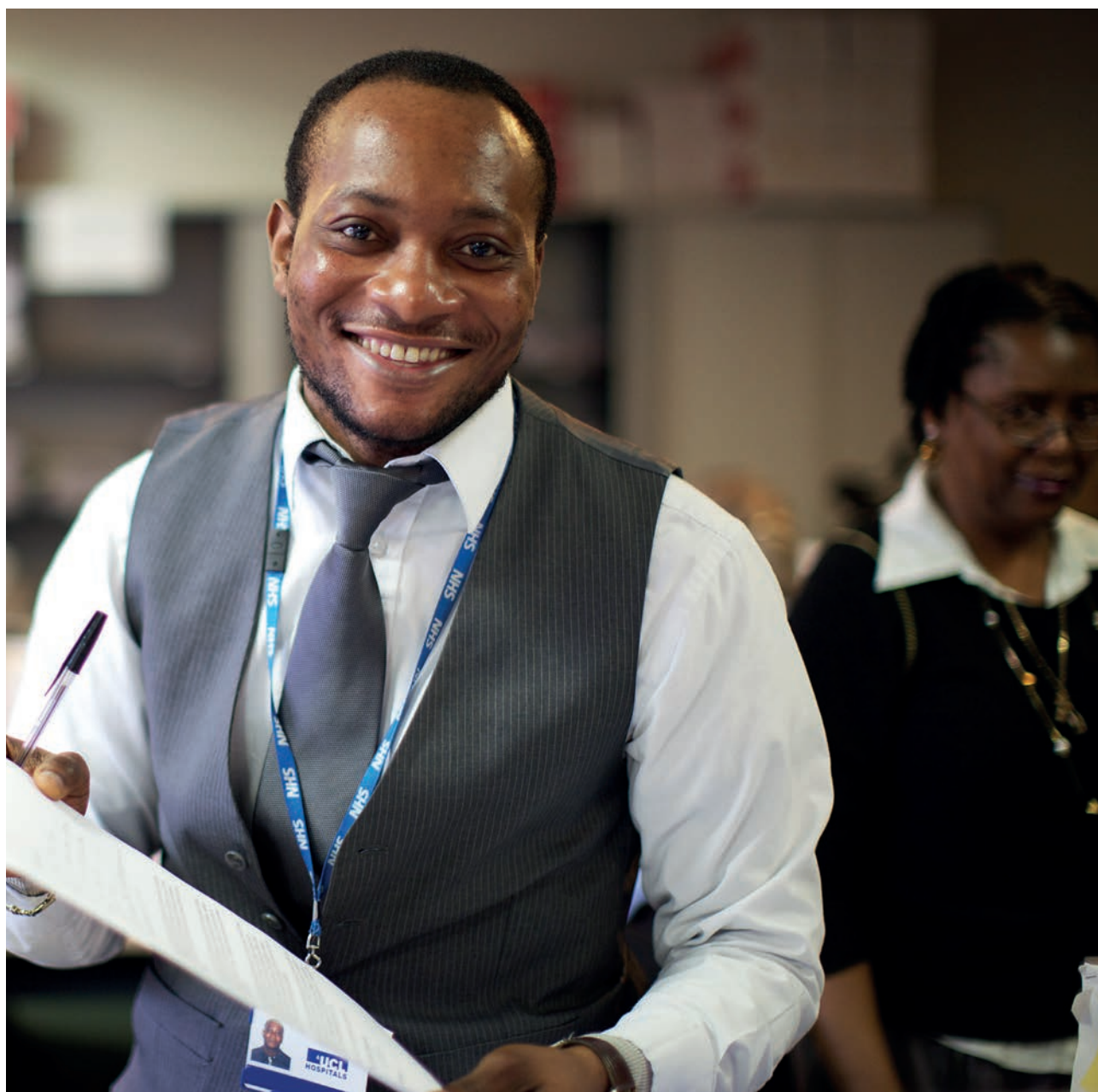
Recommendation 7:

Transitioning into undergraduate education brings many challenges, particularly for those who enter directly from school. For many it will be the first time living away from home, away from support systems and support networks, and deciding many aspects of life that were otherwise managed by parents and others. Starting university can be a stressful experience. How an individual copes with stress is the key to whether it develops into a health problem. Stress is a natural feeling, designed to help people cope in challenging situations. In small amounts it can be beneficial, pushing someone to work hard and do their best, including in exams. Self-awareness, self-care training and signposting are key to this transition being as smooth as it can possibly be. It is important that learners are able to look after their own mental wellbeing and know when and how to seek help.

Training in self-awareness, self-care, support signposting (for self and peers) and suicide risk awareness and prevention should be explicitly incorporated within each healthcare undergraduate and postgraduate curriculum.
(Wellbeing Guardian Principle Six)

Recommendation 8:

Every student will already have access to a supervisor, educators and assessors while on placement in the workplace. In addition, every student should have access to a person at a similar level within the placement organisation who can provide personal wellbeing support that is not linked to assessment or their education progression.

A wellbeing 'check-in' should be provided to all students within two weeks of starting each placement. For very short placements this may be applied to blocks of placements. The personal wellbeing tutor must have sufficient dedicated, protected time in their job plan, which is audited and reported.
(Wellbeing Guardian Principle Six)

Recommendation 9:

We have already captured in recommendation one, the proposed establishment of a Workforce Wellbeing Guardian in every NHS organisation. The Commission feels strongly that the Workforce Wellbeing Guardian should ensure that appropriate training is provided to our NHS educators, assessors and placement supervisors to equip them with the skills needed to properly support and nurture those who are learning in the NHS.

Educators, assessors and placement supervisors within NHS provider organisations should be trained and give clear guidance on support procedures for students with mental distress to allay their fears of any detrimental impact of this disclosure upon future career prospects. (Wellbeing Guardian Principle Six)

Recommendation 10:

We say much in this report about the stressful nature of transition points on the journey from school and college to university and on to the world of work (see section 3.3.1). Transitions for those pursuing a future clinical career are additionally complex when we factor in clinical placements - particularly as these are assessed placements that bring additional and sometimes complex wellbeing support needs. The HEE Quality Framework should be utilised to monitor this.

Higher education providers and NHS placement providers should recognise and proactively provide support for the transition stresses that students may face at course commencement, entering each clinical placement and on taking up their first graduate role. (Wellbeing Guardian Principle Six)

Recommendation 11:

The Commission feels that universities offering healthcare courses should undertake further work, in partnership with their students, to consider the financial and wellbeing impacts of clinical placements and rotations. This should include travel and travel time commitment, the additional burden of cost for some students associated with a need for placement accommodation, and the impact on students from disruption of formal and informal networks.

Recommendation 12:

The Commission heard that there has been a steady erosion in the provision of psychologically safe and confidential staff-only spaces in many NHS settings. The Commission felt strongly that all students (and for that matter all staff) should have suitable accessible spaces in which to socialise, share, discuss experiences and rest away from patients and the public.

The Commission was concerned by the extent to which the provision of basic support to NHS staff and those learning in the NHS has been eroded over time. We heard that in many NHS organisations there were no lockers to safely secure personal items. We heard that staff toilets were often inaccessible, but we also heard that for some, this was the only quiet time they may have on their shift. We heard that with the loss of the staff canteen, those staff who can take the time to grab a hot meal often have to contend with busy lifts on their way to the main hospital public restaurant where they then join a queue to get their food. Many staff and learners wanted the normalising experience of dropping into an on-site coffee shop for a 'good cup of coffee', visiting an on-site healthy food retail offering and then to return to quiet space. In ensuring that staff and learners have a social space to come together, to reflect and sometimes to decompress, we can support valuable peer relationships and address issues such as isolation. We believe that the public will support small, incremental initiatives which contribute to overall staff wellbeing. It would also be hard to overstate how important having access to fast, reliable Wi-Fi is to those learning in the NHS and to many members of our staff. Learners often need to connect with course work and staff during their time at work and to connect with families and their social networks. Access to free Wi-Fi and having a decent food offering for all shifts help to normalise the experience of being in a hospital for staff, visitors and patients.

When capital allocation to NHS bodies is being considered, there should be evidence that estate development plans will also enhance or create space for staff and those who are learning in the NHS.

4. Mastering mental wellbeing
The mental wellbeing of healthcare postgraduate learners

4.1 About this chapter

The Commission intended to have a focus on all postgraduate learners working in the NHS, not just doctors in training but also dentists, healthcare scientists, psychologists and others. Alas, the research literature and current feedback to the Commission has not supported this approach with the bulk of evidence being about doctors in training.

A medical graduate will have spent between four and six years in medical school. Upon leaving medical school with their degree, the medical student becomes a doctor and will gain provisional General Medical Council (GMC) registration. The postgraduate doctor will enter two years of foundation training and could be expected to gain full GMC registration at the end of the first year. During the course of two or more years, the postgraduate doctor can expect to do six to eight rotations in medical or surgical specialties.

> **" The exam seems to be a test of ability to remember obscure pieces of information rather than the ability to give a safe anaesthetic. Trying to study for an exam, work nights and weekends, miss out on life events and pay £320 a time for the pleasure is seriously getting me down. I have never felt as stupid and as worthless as I do now.**
>
> Anaesthetist in Core Training, quoted in a 2017 report on the welfare, morale and experiences of anaesthetists in training[82]

> **" It is awful being shipped around between hospitals every three to six months. Yes we get three months' notice, but it's still awful. By the time you've made connections and settled in, you are off again.**
>
> Post-FRCA Specialty Registrar, quoted in a 2017 report on the welfare, morale and experiences of anaesthetists in training[82]

4.2 Background

While postgraduate learners are integral to the provision of the healthcare service and may be regarded as members of our staff, it is important to remember they are primarily in training, but we have heard of a disconnect between expectation and reality.

Postgraduate learners require additional support, protection and have unique needs for example, rotational clinical placements which other permanent healthcare staff would not normally have. Postgraduate learners cover a wide set of professional groups, including doctors, dentists, pharmacists, healthcare scientists and advanced clinical practitioners. HEE's Quality Framework is a key tool for local reporting of learner (including postgraduate trainee) wellbeing and organisational health, linking learner experience to the quality of the environment.

The Commission has undertaken an extensive literature review and heard much evidence. However, this is not a sufficiently researched field. Research on the needs of all postgraduate professional groups as both learners and employees should be undertaken. Professional funding bodies and regulators responsible for postgraduate learners other than doctors need to identify key research questions and to support research into interventions which support their mental wellbeing.

4.3 Key questions

Our key questions for the mental wellbeing of postgraduate learners are:

1. What do we know? (Summarising the evidence);
2. What are the challenges? (Current challenges); and
3. How should we address these issues? (Themes for consideration).

4.4 Summarising the evidence - for the individual

"Her mental health suffered because of the environment she was working in. Everyone says that they can't complain about their working hours but my daughter was working 50 per cent more than she was contracted to. Other members of staff had been flagging up that she was working every hour of the day… The seniors say they no longer have time to support junior staff. The CQC go in but nothing seems to be done. There should not be juniors working there without the support that seniors need to provide."

Family member of a junior doctor, bereaved by suicide, who spoke to the Commission

Over the last two decades, interest in the health and wellbeing of healthcare professionals has grown,[83,84,85] and yet the evidence base remains largely focused around doctors. While acknowledging these limitations, we know that higher rates of depression, anxiety and substance misuse are reported in healthcare professionals compared with other workers.[86] In the UK, there are reports of higher suicide rates in some professional groups including anaesthetists and paramedics with doctors, general practitioners, community health doctors, psychiatrists, anaesthetists and female doctors identified as high-risk groups.[87,88]

The Commission heard during one panel session of work by the British Psychological Society (BPS) and the New Savoy Conference into the mental wellbeing of psychological professionals. This has led to a Charter for Wellbeing (2016) being established calling for more action to support the wellbeing of psychological professionals.

4.4.1 Risk factors

The risks for mental ill health among postgraduate learners are varied and complex.

Within the general population, additional risks for mental ill health exist for groups such as lesbian, gay, bisexual, transgender/transsexual plus (LGBT+) people, disabled people and BAME individuals. The NHS workforce is a diverse one and its employees

with these protected characteristics carry these additional mental ill health risks over and above the risks specific to working in healthcare which are described in this chapter.

The risk factors for suicide among doctors are similar to those found in the general population.[89] However, there are additional risks among doctors, including an unwillingness to seek timely help, preference to self-manage health problems, access to potent drugs, reportedly poor support networks, and ongoing investigations, complaints, court cases and inquests.[90]

Further postgraduate learner-specific risk factors are:

Personality

The profile of healthcare professionals, particularly personality traits including perfectionism[91] increase susceptibility to mental ill health.[86] There are links between perfectionism and burnout and a 'fear of failure'.[92] Levels of perfectionism have been seen to increase in society over time.[93] These personality characteristics are also attributes that make postgraduate learners highly skilled at their job. Unfortunately, these strengths, for example being "conscientious, high-achieving, driven, self-critical and obsessional" may become exaggerated during times of stress, becoming counter-productive and turning into weaknesses.[94]

Stress

Higher stress levels experienced by doctors and other healthcare professionals are linked with mental ill health.[95,96,97,98,99] Evidence suggests that junior doctors report higher levels of work-related stress and burnout and lower engagement than more experienced staff.[100,101] The Society of Occupational Medicine states that: *"The number of hours that doctors work has officially reduced to comply with the European Working Time Directive. Nonetheless, doctors' mental health has not necessarily improved and there is evidence that factors such as poorly-designed rotas, staffing problems and more shift work have negated the intended benefits of fewer working hours."*[168] Stress has been identified as a primary health concern for pharmacists[102] with excessive workload perceived as key contributor.[103]

The transactional stress model (Lazarus 1990)[104] considers how stressful, threatening and controllable a situation is and the resources an individual has to cope with the situation. Both are likely to be affected by NHS culture and workforce demands. We know that stress is believed to account for more than 30% of sickness absence, costing the NHS £300 million and £400 million per year (NHS Employers).[105] There are a multitude of factors increasing stress levels, including loss of psychologically safe and confidential spaces for colleagues to share the emotional aspects of their work, service pressures reducing time with patients, and loss of time to digest the emotional burden of work. Stress is also linked to unhealthy behaviours such as smoking, alcohol and substance misuse and poor diet - all having negative effects on mental wellbeing. NHS Employers has produced an emotional wellbeing toolkit,[106] and guidance on the prevention and management of stress in the workplace, and these are examples of steps in the right direction.

Emotional involvement

"Compassion, caring and empathy - these are the qualities that are sought and these are the ones that bring people down."

Family member of a junior doctor, bereaved by suicide, who spoke to the Commission

Working in healthcare requires high levels of 'self-giving' and emotional involvement. Managing emotions results in more effective workplace interaction. The negative impact of 'emotional and cognitive labour'[107] associated with care-giving can result in stress and burnout.[108] Learning and building resilience helps mitigate these risks and improves outcomes for the individual and patients.[109] 'Emotional labour' has been defined as the effort required to show emotions (such as sympathy and understanding) that are appropriate to a professional role but not actually experienced, and to suppress emotions that are felt (such as frustration and disgust) that would be inappropriate to show publicly.[110]

The question for this Commission has been the extent to which NHS managers and clinical leaders

working in the care setting recognise the impact the care-giving 'work environment' has on the care-giving clinical staff. The Commission notes the introduction of a Guardian of Safe Working as one of the conditions of the 2016 Junior Doctors Contract where issues such as workload and stress can now be raised. However, the role description does not include any specifications regarding caring for the mental wellbeing of doctors. We believe that a recommendation of this Commission to introduce a NHS Workforce Wellbeing Guardian (*recommendation one*) will make a significant difference.

Well-supported staff whose own mental wellbeing needs are being met by their employer, must be better clinicians who deliver better, safer and more patient-centred care.

Among some postgraduate learners, the term 'resilience' has negative connotations, implying that they are emotionally weak. There is also some academic contention regarding the term. Asking individuals to improve their resilience without acknowledging that the system they work within can seem almost designed to foster poor mental health may worsen the relationship between postgraduate learners and their employers. Resilience can be seen as having the tools to self-care. This can enable postgraduate learners to accurately perceive emotions, integrate emotions with cognition, understand emotional causes and consequences and manage emotions for personal adjustment.

Hidden curriculum

Within postgraduate training, there are aspects of the 'hidden' curriculum that impact learner behaviours and attitudes. This is particularly relevant to cultural competency.[111] Cultural competency in healthcare involves recognising and responding to key cultural features that affect clinical care.[112] Postgraduate learners, acting in an 'apprentice' role, are strongly influenced by organisational culture and their supervisors/role models.

Presenteeism

Presenteeism is defined as coming to work and performing at a reduced level of productivity due to ill-health. This is particularly relevant for postgraduate learners who may worry about workload, stigma, fear of harming future career prospects or letting their patients and colleagues down.[113] Increasing pressures through rota gaps are important in that when a rota is already stretched, there may be more (self-imposed) pressure not to take time off. The financial implications of presenteeism are well recognised, costing the NHS more than sickness absence.[114]

Regulation

Doctors report to us a general atmosphere of 'fear', in particular fear of investigation and associated uncertainty relating to investigation, blame and prosecution.

Indeed, as the recent Williams review found, doctors 'perceived arbitrariness and inconsistency'. While this statement applied to gross negligence manslaughter, it chimes with the views expressed to us during this first phase of the Commission.

The intense pressure and scrutiny that doctors face when they are referred to the GMC due to a complaint or health concern investigation is likely to be a shared experience for any clinician under similar circumstances. Postgraduate learners may experience anger, depression, shame and loss of enjoyment in practising medicine immediately following a complaint.[115] The GMC has undertaken considerable work including its own commissions regarding how to better support those under investigation and the Commission heard evidence of improvements in processes and timescales already.

The Commission notes that the GMC reports that some BAME doctors and non-UK graduates are more likely to receive sanctions and warnings than white doctors and UK qualified doctors respectively.[116] Similar trends have been noted in nursing and dentistry.[117] A key factor, confirmed by independent studies, is that employers refer proportionately more BAME and non-UK graduates to the GMC compared with white doctors and UK graduates[118] and employer referrals to the GMC are more likely to lead to sanctions or warnings than patient complaints. The GMC has commissioned Roger Kline and Dr Doyin Atewologun to conduct

an independent study to better understand why some doctors are referred to the regulator for fitness to practise issues more than others and the Commission welcomes this research (due to conclude in early 2019).

The regulatory process that doctors in training undergo following a complaint has been described as 'death by 1000 arrows'[119] as the process involves investigation by a range of bodies. This multiple jeopardy process is often drawn out over years and may lead to mental ill health and even suicide.115 All the regulators of the regulated professions in healthcare need to be alert to the impact their processes have on their registrants. It is right for patients that complaints against regulated clinical professionals are thoroughly investigated but it is also right for the clinicians to expect that such complaints are managed fairly, openly and promptly.

Vulnerability

Healthcare organisation, culture and workload can combine to make healthcare professionals as vulnerable to unhealthy lifestyles as the general public, despite their increased knowledge about the attendant risks and the importance of maintaining good health.

Bullying and harassment have been linked to stress, depression and sickness absence.[120] Postgraduate learners may be more susceptible to bullying and harassment as vulnerable groups include younger, potentially less experienced healthcare professionals, those born overseas, working in emergency care and in psychiatry.[121] Historically the GMC National Trainee Survey also showed specialty specific variation in levels of bullying, for example, with higher levels of bullying and undermining in obstetrics and gynaecology which the Royal College of Obstetrics and Gynaecology has worked hard to address including introducing a workplace behaviours advisor. Vulnerability to bullying and harassment also extends to BAME colleagues including those born in the UK.

Substance and alcohol misuse

Substance misuse can contribute to and exacerbate existing anxiety and depression and can impair sleep. The detrimental impact of drug and alcohol misuse on postgraduate learner wellbeing can lead to absenteeism, presenteeism and risk patient safety. A survey of junior doctors reported one in three male and one in five female doctors had used cannabis.[122] Thirteen percent of junior doctors reported previous use of ecstasy, cocaine and other hallucinogenic drugs. The same survey reported two-thirds of junior doctors exceeding safe alcohol limits. Substance misuse problems among dentists and pharmacists[123,124] is also evident. A survey of 545 UK dental professionals showed that 6% had a 'drink problem' and 9% had 'alcoholic tendencies'.[125]

Stigma

Postgraduate learners are likely to fear stigma and possible discrimination if diagnosed with mental ill health.[126]

Compared with other healthcare professionals, doctors in training are more concerned about stigma related to mental ill health, particularly the impact admitting a problem at work may have on career progression. Self-stigmatisation, which may emerge from the belief that 'doctors are invincible,' leads to deliberate concealment of problems. Doctors suffering from mental ill health have described themselves as 'failures' and internalise the perceived negative responses of colleagues to their illness.[127] This was strongly supported in Commission evidence sessions.

Concerns that health problems may damage a clinician's reputation are not unfounded since 39% of the general public confirm they would not feel comfortable being treated by a healthcare professional with previous mental ill health.[113] Unfortunately, this finding only serves to propagate stigma further.

Re-charging the batteries of Taunton's trainees
The wellbeing at work approach of Taunton and Somerset NHS Foundation Trust
and Somerset Partnership NHS Foundation Trust, with support from HEE South West

"In order to provide compassionate, safe and high-quality care, staff wellbeing is paramount. We cannot expect to look after others if we don't look after ourselves and our teams."

That is the view of Dr Anna Baverstock, consultant paediatrician and associate director for medical education support at Taunton and Somerset NHS Foundation Trust, who has a trust-wide remit to support junior doctors, a role independent from the clinical and educational supervisor.

Dr Baverstock says: *"Using the analogy of a phone battery that drains and needs recharging is how I like to think about each aspect of wellbeing. We often are aware when our phone is on red and needs to be plugged in but how often do we do a battery check for our own personal reserves?*

"Traditionally we often think of ourselves as 'draining' reserves at work and 'recharging' at home. This however does not enable us to function well for the whole of the working day. In reality we need to think about how we recharge through the working day to enable compassionate, high quality care from the beginning of our shift to the end. There is increasing evidence that rest and regular breaks need to be prioritised. How do we ensure that the last patient on the ward round, list or clinic gets the same quality of care, compassion and communication?"

Musgrove Park Hospital, run by the trust, is a 700-bed district general in Taunton, Somerset, which prides itself on 'being one of the friendliest hospitals to work in'. Junior doctors are made aware of the support and resources available at induction, all located on the staff intranet. A wellbeing booklet brings together important information such as the support available following a complaint or challenging incident, advice on rest and optimising sleep ahead of night shifts, and flow chart advice to follow if someone is acutely worried about the wellbeing of a colleague.

Foundation trainees have a pastoral (or personal wellbeing) tutor and also support from occupational health. There is a confidential reporting system for any claims of bullying and harassment and an employee assistance programme which provides telephone support including counselling. The promotion of positive health at work has been widened out to all hospital staff with a trust-wide Wellbeing Month, led by a dedicated Wellbeing at Work team. This links in with the trust's HALT (hungry, angry, late, tired) campaign which has featured training sessions about removing the barriers to taking a break at work. In further developments, 'Balint group' meetings are being introduced for staff teams to be able to examine their practice in an open, shared, learning environment.

Dawn Coleman, trust wellbeing lead, is dedicated to helping create a happier and healthier workplace. She says: *"There is a philosophy that work is good for you - it is actually good work that is good for you. If it is not good, the workplace can be an awful place to be. Work is a place where you need to feel happy and well, supported by each other, with kindness to each other. When under pressure we can lose the ability to be kind to each other. Some people say you cannot measure kindness, but you can certainly measure the absence of it."*

4.5 Summarising the evidence - for the healthcare system

4.5.1 Healthy workforce equals healthy patients

The health and wellbeing of all healthcare professionals, including postgraduate learners is a priority in providing patient-centred, high quality care.[128,129,130] Research has shown that there are links between staff psychological wellbeing and patient experiences of care and that doctors' psychological distress negatively impacts patient care and the healthcare system as a whole.[131,132,133,134] Medication errors have been reported as being far higher among junior doctors affected by depression compared with colleagues in good health. Therefore, in considering the stigma of mental ill health any action to address this stigma needs to be clear that there may be risks, and performance may be adversely affected, but it can be safely addressed and it is better and safer for this ill-health to be identified and addressed in a supportive fashion.

Work can be good for health but conversely, the working environment may lead to ill-health and professional problems.[135] The impact that workplace structure and organisation has on mental health risk in clinicians is greater than the impact of dealing with sick and dying patients.[86]

4.5.2 Support services

Services for postgraduate learners with health concerns do exist and are improving but offer variable levels of support and may only serve a geographical region.

In secondary care, occupational health services are the primary source of support for postgraduate learners. The National Clinical Assessment Service was established in 2001 as an advisory body to help resolve concerns about the practice of doctors, dentists and pharmacists. The Department of Health's *Invisible Patients* (2010) publication raised awareness about the difficulties faced by health professionals with mental ill health accessing appropriate care.

There are several services that have been established for doctors, and doctors in training, but dedicated services for other postgraduate learners are limited. Such services include the *Practitioner Health Programme*,[136] *BMA Doctors for Doctors* service, *Doc Health*, *Health for Health Professionals,* and deanery support units. Despite these services, a survey of doctors about how they would access support for mental ill health, revealed only 6% would go to occupational health first. This survey also showed that no doctors in training would choose to go to their deanery support unit, despite this being the recognised pathway of support.[137]

4.6 Current challenges - for the individual

The current challenges facing postgraduate mental wellbeing are set out below although in some cases the Commission notes that they apply equally to staff at all stages of their working lives.

4.6.1 Accessing health services

Postgraduate learners do not access health services in the same way as the general public.[86] Doctors are known to prefer informal 'corridor consulting' with a colleague and frequently self-prescribe to save time. Denial about health problem severity and inadequate clinical care are common consequences of self-treatment. Postgraduate learners may be deterred from accessing services in a timely manner due to fear of stigmatisation, lack of time, work pressures and concerns about confidentiality.

Even when postgraduate learners do access formal channels of care, they may be treated as colleagues rather than patients. All doctors (including trainees) should access healthcare through appropriate channels. Unrealistic expectations about recovery, assumptions about treatment compliance and inadequate follow-up are potential barriers to resuming good health.

4.6.2 Disclosure

There are a wide range of psychological and socio-cultural factors that affect disclosure in postgraduate learners. Junior doctors are particularly vulnerable as they are less likely to disclose mental ill health than consultants.[137] A survey of 3,500 doctors' showed that 73% would choose to disclose mental ill health to family

or friends rather than a healthcare professional. This finding was reinforced in a survey showing 97% of doctors would choose to confide in someone outside of the workplace first.[137] Not wanting to be labelled [137] and the perceived adverse effect on career [139] were cited as key obstacles to disclosure. A better understanding of the 'tipping points' that lead postgraduate learners to disclose is required.

4.6.3 Transition from undergraduate to postgraduate training

While undergraduate learning provides a foundation of knowledge and skills, the appropriate support for postgraduate learners to transition into a stressful working environment may be lacking. Potential negative factors that contribute at this time include increased clinical responsibility, reported unrealistic workloads, long working hours, inadequate staffing levels and a stressful environment.[95] Poor coping behaviours are learnt early on in healthcare careers and the provision of comprehensive support during undergraduate years may avoid stress and distress during postgraduate training and beyond.

4.6.4 Rest and relaxation

Arguably, the biggest impact on postgraduate learners' wellbeing would be to improve working conditions including adequate facilities, rest breaks, hydration and nutrition.

This has been emphasised by recent publications [82,140] and reports by postgraduate learners; an anaesthetist in training reported:

"It's the little things at work which impact morale: lack of lockers, clothes getting stolen from the changing rooms, lack of on-call rooms and having to rest on the floor or uncomfortable chairs. The fact that you can work a 13-hour shift and not have anywhere to go and get food overnight is sort of ridiculous and you wouldn't expect it in any other profession."

Trainee physician, Royal College of Physicians. Work and Wellbeing in the NHS: Why staff health matters to patient care. London

The environment in which we work in the NHS and in which we interact with patients, carers and their families is important and should not be overlooked when considering the wellbeing of our undergraduate and postgraduate learners, staff and those considering a career in healthcare. Many NHS hospitals have given great thought to the provision of personal space for their staff (lockers, changing rooms, rest areas and multi-faith quiet areas) and place great importance on ensuring that the public spaces that are shared with staff are as normalised as possible; such good practice needs to be more widespread. The Commission has heard of the importance of psychologically safe and confidential spaces away from patients and the public where staff have privacy to socialise and informally debrief. We heard that the sense of community within NHS settings has been eroded and needs to be restored.

It is increasingly acknowledged that lack of sleep can significantly impact a healthcare professional's performance at work during night shifts. Night shift workers are more likely to make simple mistakes and avoidable errors, leading to increased risks to patient safety.[141]

They are also at increased risk of road accidents after a shift.[142] Hospitals must consider how to implement strategies around rest on night shifts that ensure staff can continue to function at their best, and that staff safety is taken into account.

4.6.5 Isolation

"My daughter was a really good musician, and over the years she relied on her music to repair herself and relieve herself of stress, and though you can do music by yourself, it is largely a group activity and she found her ability to do that curtailed by the inflexibility of her job."

Father of a junior doctor, bereaved by suicide, who spoke to the Commission

Isolation based on shift-work patterns and poorly functioning teams has been identified as a factor in mental ill health in vulnerable clinical individuals.[136] This is a highly relevant risk for postgraduate learners whose social support network is fractured by the rotational nature of their clinical placements, often in locations away from their partner, friends and family. This is seen to be worsened by working unsociable hours and the loss of the traditional consultant-led 'firm' structure. In reality, such 'firm' structures only existed for larger specialties and changes to working patterns and healthcare delivery are such that it cannot be widely recreated. However, the HEE work on the *Modern Firm* review offers potential to realise what was seen as good in firms and also embraces and supports the wider clinical care team. Furthermore, through the implementation of *Enhancing Junior Doctors Working Lives,* HEE is reducing rotation frequency and ensuring longer placements. This enables the doctor in training to establish team relationships and to achieve better work-life balance and access to local support networks.

4.6.6 Reactive

Unfortunately, postgraduate learners tend to access support services late and as a reactive measure to a mental health crisis. This poses a challenge since early intervention has been shown to lead to improved outcomes in mental ill health.

The wounded healer
Practitioner Health Programme celebrating its first decade

The Practitioner Health Programme (PHP) is a confidential, free, self-referral NHS service for doctors and dentists with mental ill health and addiction problems. The service operates nationwide and can offer a range of pharmacological treatments and talking therapies. The service was launched in 2008, initially only for a two-year London pilot. Having won several awards over the years, the service is now available to 85,000 doctors and is accessed by about 1,500 individuals every year.[138]

Dr Clare Gerada, PHP Medical Director, said: *"The old saying that doctors make bad patients is true to a degree. Doctors are reluctant to come for help. They think that they are alone, the only ones ever to become unwell or need help. They describe being ashamed at having to admit to vulnerabilities and believe that in one way or another they are letting people down by being ill. Over the years we have found that sick doctors, as with all patients, yearn to be treated compassionately - with sensitivity, sympathy, empathy and in a non-judgmental manner. All too often, however, mentally ill doctors are treated by trainers, employers and regulators as naughty schoolchildren or wrongdoers at having crossed the boundary from practitioner to patient. Unfortunately, the needs of the doctor as a patient - a troubled, desperate and unwell patient - are ignored by most treatment agencies."*

More information available at: http://php.nhs.uk - the website has a number of resources including complaints handling, facing a disciplinary process, and self-disclosure of a health issue.

4.7 Current challenges - for the healthcare system

4.7.1 Organisational culture

Workplace organisation and culture can promote or undermine the mental wellbeing of postgraduate learners. Inter-personal conflict, low levels of support and a feeling of being poorly managed are detrimental to wellbeing whereas good relationships with colleagues and supervisors are protective.[143] Stories are commonplace of postgraduate learners and their supervisors/mentors sharing feelings of disenfranchisement and demotivation. Addressing the mental wellbeing of postgraduate learners necessitates a change in organisational culture to improve morale and wellbeing among all healthcare staff.

4.7.2 Support services

The current system for postgraduate training is seen as prescriptive and rigid. The rotational nature of clinical placements is said by some to prevent consistency, fracture social networks and may lead to postgraduate learner isolation. For those with mental ill health, there is a lack of co-ordination of support services across rotations, which may increase vulnerability. Sharing of information, while respecting confidentiality, is needed to ensure appropriate support is in place before the postgraduate learner transitions to their next placement. The most effective way to raise awareness about support services available to postgraduate learners in each placement is not always apparent. Clearer, more proactive dissemination at induction sessions as well as via online/social media should be considered.

4.8 Themes for consideration - for the individual

4.8.1 Respect, recognition and being valued

Within healthcare, postgraduate learners are still perceived as lower ranks and junior within the NHS hierarchical system. This fails to recognise the accomplishments of all postgraduate learners. Many doctors in training will have more than 10 years' clinical experience, higher postgraduate degrees/

qualifications and be independent practitioners in specialist fields. HEE has commissioned work, now underway, to consider appropriate terminology that better describes those often referred to as 'junior doctors'. We will access advice from HEE's Patient Advisory Forum as proposals emerge. Workplace culture needs to recognise the value that postgraduate learners bring to the healthcare environment. Simple measures to improve the wellbeing of postgraduate learners would include the provision of hot, nutritious food during night shifts and adequate facilities to rest in during long, intensive shifts. Currently, there is a wide variation between hospitals in terms of access to (and quality of) rest facilities and food overnight. The list is far from exhaustive with other issues such as access to safe car parking, costs of parking, response to incidents and many others also impacting. This disparity of provision for rotating doctors means that their quality of experience can be vastly different even between hospitals in the same close geographical area. The BMA has produced a *Fatigue and Facilities Charter*[144] to address the mounting effects of sleep deprivation, fatigue and burnout. Much of this is about ensuring that employers genuinely value their staff and staff genuinely feel valued.

4.8.2 A portfolio career

The life aspirations of postgraduate learners are at odds with a 'conveyer-belt' model of healthcare training. There should be more flexibility for a varied work-life balance and personal development opportunities in academia, leadership and management, and entrepreneurship. A better understanding of postgraduate learner motivations and expectations will help identify ways to support these individuals to stay in a lifelong healthcare career.

The GMC report, *Taking Revalidation Forward,*[145] stated: *"As patient expectations of healthcare have developed, so have models of care and the attitudes of doctors towards their work. Today's doctors operate in a multi-generational and multi-skilled workforce of healthcare professionals. The motivations and expectations of each generation are different. For example, the newer generation of doctors seeks greater flexibility in working hours and has different expectations of managers and leaders.*

"… in comparison to earlier periods, current doctors in training are less likely to complete their training in a single concentrated period, fewer GPs wish to become full-time partners in a practice and locum work is proving increasingly attractive as a means of balancing work and family commitments. Doctors, particularly younger doctors, spoke … about an aspiration to have a portfolio career where medicine might be only one part of that career."

A change in culture and attitudes within the healthcare environment is needed to validate postgraduate learners' choice for more flexibility in training. HEE launched the pilot for flexible training in emergency care from the *Enhancing Junior Doctors Working Lives* working group and this has had a positive response. Conventionally, pursuit of skills outside the clinical domain is disparaged or considered inferior to clinical training. We would propose active encouragement to pursue these skills.

This is a key application of HEE's exploration of the application of credentialing which is critical in developing a diverse workforce adaptable to the ever-changing healthcare landscape. Credentialing is an opportunity for wider workforce development, offering greater flexibility.

4.8.3 Mentorship and supervision

The current system of supervision has an inherent conflict of interest since mentorship/personal wellbeing support is typically provided by the same individual who fulfils the trainer role with responsibility for assessment and ultimately postgraduate learner career progression. This weakness within the system needs to be addressed and how we achieve safe reflection and reflective practice, effective supervision, assessment, appraisal and mentorship and personal wellbeing support carefully considered.

Work is required regarding the separation of personal wellbeing support from line management and from the education and progression assessment processes to address the conflict of interest expressed by learners. HEE has initiated this with its review of educational supervision which has cross-system support and will be applicable to all healthcare learners and their educators. HEE has also allocated working groups dedicated to education support, and supporting and valuing learners, in the foundation programme review. The Commission heard several times from families of NHS staff bereaved by suicide of the need to separate personal wellbeing support from line management and from the education and progression assessment processes.

Acknowledging and understanding the implications of generational differences between supervisors and postgraduate learners is critical to defining the optimal trainer-trainee relationship. The impact that generational differences have on supervision and mentorship may not be equivalent. For example, is peer-to-near peer mentorship more desirable for postgraduate learners or is it preferable to have a supervisor from a different generation with a wealth of knowledge and experience?

4.8.4 Preparing for failure

Undergraduate training has an important role in preparing postgraduate learners for the stressors they will face in the healthcare workplace.

Developing postgraduate learners' skills to recognise and cope with signs of stress[146] is as important as preparing these individuals for inevitable errors/ failures. In both undergraduate and postgraduate settings across professions, the reflective learning component of curricula is vital to lifelong learning and safe and reflective clinical practice.

A culture shift in the way failure is perceived in healthcare is needed to support postgraduate learners to learn effectively from openly disclosed errors and view occasional 'failure' as significant for personal development - in the same way as success is valued for personal development.

Reflective practice is: *"The process whereby an individual thinks analytically about anything relating to their professional practice with the intention of gaining insight and using the lessons learned to maintain good practice or make improvements where possible."*[147]

It is also an important tool by which systems change and patient safety improvements can be made. Trainees are encouraged to partake in reflective practice throughout their career (and indeed many specialities require written logs of reflective practice). There has been concern that these private logs could be used against an individual in complaints and legal processes. In response, the GMC, Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans and the Medical Schools Council have produced

reflective practice guidelines. Trainees should be encouraged to follow these so that the value of reflective practice is sustained without fear of this important learning process being used against them at a future date.

4.9 Themes for consideration - for the healthcare system

The themes emerging for the system on postgraduate mental wellbeing are set out below. The Commission notes that some themes apply equally to staff at all stages of their working lives.

4.9.1 Compassion and fairness

Establishing a culture of compassion within the workplace and promoting organisational fairness would enhance the wellbeing of postgraduate learners significantly. If postgraduate learners perceive their employing organisation to support fairness in distribution, procedures and interaction with them, their wellbeing, performance and job satisfaction will be improved.[148]

Adopting an organisational culture of transparency and accountability, particularly relating to near misses and serious untoward incidents, patient queries and complaints will encourage postgraduate learners to raise concerns without fear of retaliation.[90] Work-related stress is significantly reduced in clinicians when they feel their employers are responsive and supportive. A combination of compassionate leadership, effective change management, good clinical supervision and educational support will increase feelings of competence, wellbeing and job satisfaction in postgraduate learners, all of which will engender a culture of safety for all staff and patients.[149]

4.9.2 Thoughtful implementation

Co-production is imperative for the successful implementation of any recommendations or interventions to improve the mental wellbeing of postgraduate learners. Other factors to consider include adherence to evidence-based models, co-location and data sharing to enable interventions to be integrated, and robust execution including project management and governance.

A just and learning culture
Mersey Care NHS Foundation Trust

The 'just and learning' culture at Mersey Care NHS Foundation Trust is a restorative practice approach which recognises that in an untoward incident care-givers can be victims too. This significant shift in organisational culture came at the culmination of a journey, advanced in part by trade unions concerned at what seemed to be an unfair and distressing process for managing adverse incident investigations and human resources policies and processes.

In response, in 2016 Mersey Care engaged with staff to understand staff perceptions of the organisation regarding the handling of errors. They found that feelings of fear, being blamed, shamed or even dismissed permeated throughout the workforce. This created a barrier to reporting incidents and staff described feeling inhibited about speaking for fear of retribution.

It was felt that the processes in place for managing adverse incidents were positioned towards finding a mistake and apportioning blame, and in many cases resulted in suspensions. The Commission heard that the trust view at the time was that suspension provided a safe and without prejudice approach and was felt to be in the best interests of patients. Staff though felt the approach was punitive and contributed to stress, anxiety and ill health.

A video[150] has been produced describing the process followed by Mersey Care. Amanda Oates, Mersey Care Executive Director of Workforce, said: *"I cried when I heard first-hand about the impact of the consequences that my organisation had had on people's lives."*

Driven by a desire to rebuild their relationship with their staff and inspired by the work of Professor Sidney Dekker, Mersey Care committed to changing the process. A position was adopted that people, in general, do not purposefully cause harm or pain to others. This has allowed them to move processes away from retribution towards a restorative approach based on relationships and learning.

Mersey Care now deal with adverse incidents expediently and informally to reduce the impact of lengthy investigations on staff wellbeing. Disciplinary interventions have also been dramatically reduced. The focus has been firmly shifted from a blame culture to a learning culture, with leaders better able to admit when they have got things wrong. In addition, the trust has introduced support for staff in difficult circumstances especially those involved in adverse incidents to create a wrap-around of compassion and care.

The benefits of this enlightened approach are widespread. Indicators of wellbeing improvement include reduced sickness absence and lower staff turnover. Mersey Care can evidence a safer environment for patients as the reporting of adverse incidents and near misses has risen as staff confidence on being treated fairly has increased. In economic terms, Mersey Care estimate a total saving of between £1 million and £2.5 million based on the combination of the reductions in absenteeism, staff turnover and legal and termination costs.

Recommendation 13:

Every postgraduate trainee will already have access to clinical supervision and educational supervisors in the workplace. In addition, every trainee should have access to a person at a similar level of seniority within the placement organisation who can provide personal wellbeing support that is not linked to assessment or their education progression.

A wellbeing 'check-in' should be provided to all postgraduate trainees (within two weeks) of starting the placement and on each placement. The personal wellbeing tutor must have sufficient dedicated, protected time in their job plan, which is audited and reported. (Wellbeing Guardian Principle Three)

Recommendation 14:

The Commissions heard from learners of a major impediment to seeking help being fear, including a lack of clarity on the boundaries of disclosure and confidentiality including relation to fitness to practise procedures to allay fears of detrimental impact of disclosure upon future career prospects.

Educational and clinical supervisors within NHS provider organisations should give clear guidance on their local support for postgraduate learners with mental distress.

Recommendation 15:

The Commission heard that there is a need for the NHS to recognise that there are additional needs for on-call staff and learners. These include access to the best possible on-call sleep rooms that are secure and safe, changing and shower facilities, and refreshments including where possible hot food. On-call staff and learners may also need to sleep on site after an on-call shift before they are safe to travel home. The Commission heard of remarkably uncaring barriers being put in the way of the use of suitable on-call facilities.

Trainees working on an on-call service must be provided with rest spaces and 'designed for purpose' on-call rooms that enable rest and sleep either during, before or after on-call shifts. (Wellbeing Guardian principle six)

Recommendation 16:

It has been evident to the Commission that some staff are impeded from accessing help as they are concerned that they could/ would be identifiable, either because of their prominence or their visibility and would therefore run the risk of being known by colleagues.

The Department of Health and Social Care and the NHS should implement a service which will 'ensure rapid access' referral pathways for NHS learners and NHS employees based upon a prioritisation request from either a primary care or occupational health clinician.

It is additionally recommended that, services must be flexible enough to ensure access for those clinical staff that have additional barriers to accessing local services. Examples might include doctors in the same NHS provider body or healthcare professionals with mental health problems, or addictions and other conditions that may be better served by a more confidential service. Services should be commissioned to ensure safe, confidential and timely access.

Recommendation 17:

Much work has been done by HEE Enhancing Junior Doctors Working Lives to understand the needs of learners and there is also work in the Foundation Programme Review. It is clear that there are key changes that can enhance trainee morale and access to support networks. Vital changes include increased placement length, early notification and greater flexibility of placement.

The Enhancing Junior Doctors Working Lives changes must be fully implemented and should be applied to all postgraduate trainees, not just doctors.

Recommendation 18:

Recruitment is a competitive process with post-allocation based largely on performance at selection with few exceptions for specific factors. The Commission has heard of an 'inverse care law' of trainees who perform better at selection obtaining higher quality placements, whereas lower scoring candidates, by virtue of not securing their placements of choice, being more likely to be removed from normal social and personal wellbeing support networks and systems. Thus, doctors and scientists performing less well at selection are placed in the less popular units and removed from their support systems.

HEE, medical schools, United Kingdom Foundation Programme Office and Medical Royal Colleges need to work with Medical Students and Doctors in Training to agree an allocation system that is both just and more humane.

5. Supporting our staff
Mental wellbeing in the workplace

5.1 About this chapter

For the most part, people enter healthcare employment because they want to care and heal or because they simply like working with people. Work is good for us[151] and the vast majority of people who come to work in the NHS every day do so because they love their job, they enjoy the people they work with and they take great pride in knowing they are there to help and support patients, carers and families. The relationship the public has with their NHS is unique and staff working in the NHS can be seen as custodians of the nation's most prized possession.

The NHS Constitution reminds us that: *"…the NHS is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science - bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most."*

For many considering a career in the NHS, these words resonate. But there is a side of the NHS - the NHS as an employer - which the Commission saw and heard about that was deeply concerning. Despite the NHS wanting to become the employer of choice locally, many parts of the health service have a troubling problem with workforce retention and recruitment. We heard staff talking about being under so much pressure that the 'workforce is running on empty'. Bullying and harassment are unacceptable anywhere in the NHS but the Commission heard evidence of cases where it has seemingly been normalised and tolerated.

The Commission heard that NHS teams feel under constant pressure in a service where demand seems relentless. They experience the impact of staff sickness and staff shortages or rota gaps and this only increases the demand on them which can seem overwhelming. We heard from staff and those who are learning in the NHS who feel reluctant to take a break during their lengthy shifts. We heard stories where people were delaying a visit to the toilet and even feeling 'guilty' about taking time to eat a meal, knowing that when they are out of the department, not available on the ambulance, not covering the practice or off the ward their colleagues will be under even greater pressure. In this febrile environment, the basics of good employment practice seemed in some parts of the NHS to be lost.

We heard staff express concern that they were expected to do ever more with less resource and yet, paradoxically, they seemed understanding of their supervisor or manager for demanding more of them. But the point where gentle persuasion becomes inappropriate - is where hectoring and harassment, possibly even moral exploitation, takes over. We heard of staff being 'pressured' to do yet another extra shift. The Commission was told of pressure to readjust the rota even when a holiday had been booked and we even heard that a junior doctor who had booked time off work to get married had found himself rostered onto a night shift the day before his wedding. Staff spoke about feeling stressed - beyond that normally experienced in what are often demanding roles and they felt that this was being increasingly *normalised* in an NHS operating under unprecedented levels of demand. This chapter will look at the question: *'who cares for those who care for the nation's health?'*

Working in the healthcare sector is like no other employment environment. Daily, our staff are confronted with the extremes of joy, sadness and despair; a spectrum that encapsulates the euphoria of a new child successfully brought into the world and a loved one saved from certain death through the skills of the clinical team. This emotional labour is often exhausting. As was described to the Commission, many of our clinical staff retain a collection of curated traumatic memories of death and dying. Many of our staff, often young staff, see the horrors of extreme trauma; they see the aftermath of major road traffic accidents, suicide, and they see children in distress or dying and they help families cope with the loss of a loved one. They see the effects of deprivation and many see, what they described to us as 'life in the raw'. These memories, like ghosts from the past may return at unexpected times. The emotional labour required to manage this rollercoaster for NHS staff is often

taken for granted by the individual and by the NHS itself, but the Commission found that there are dangers to this which can profoundly impact upon the wellbeing of staff.

The NHS is of course not one employer. It operates in hundreds of settings across every community in the country, deploying its people as members of significantly sized organisations largely in the statutory sector (trusts, foundation trusts and CCGs) but also in other NHS commissioned providers (general practice, pharmacy, dentistry as well as other groups), charities and community interest companies. Teams work across a diversity of settings and with different patient and client groups.

The NHS staff survey, applied to all secondary care NHS providers, shows real variation in the experience of people working in the NHS. In relation to health and wellbeing for example 38.4% of all respondents felt unwell due to work-related stress in the previous year, with 49% of ambulance respondents and 41% of mental health/learning disability colleagues reported feeling unwell. In relation to job satisfaction, acute specialist trust employees report a greater recommendation of their place to work (4.09/5.00) than ambulance trusts (3.43).

I was getting flashbacks, I was getting an hour's sleep a night. I was going to bed and getting up after an hour, I couldn't sleep so I would be pacing around the house. I would be sitting there and replayed every second of that job in my head thinking 'could I have done anything different?' I could very easily at a couple of points have felt sorry for myself and topped myself because I have never been so low in my life.

Anonymous, an ambulance paramedic whose story was told to the Commission. The male paramedic had attended a paediatric cardiac arrest.

It is an odd anomaly that in a professional culture which deals with caring, there is still a lack of support for simply asking, 'are you ok?' and meaning it.

Paul Farmer, Chief Executive Officer, Mind, personal communication

5.2 Background

The NHS is a world-renowned healthcare system. It employs a professional clinical workforce that is caring, committed, hard-working, compassionate, resilient and adaptable. The public are highly satisfied with the NHS. Recently published independent data spanning three decades shows that current public satisfaction with the NHS is higher than in all but three of the past 30 years.

As we celebrate the successes of the NHS including the delivery of high quality care for a population enjoying increasing life expectancy, there is concern about the toll this may have on the NHS workforce's ability to continue to deliver such high standards against a backdrop of declining workforce retention levels, workforce shortages, and a significant slowing down in the rate of applications to some clinical undergraduate courses.

Demand for NHS services ever increases, and we continue to hear a narrative of NHS workplace stress and burnout, or *'Operational Stress Syndrome'* as it has also been termed in evidence to the Commission. Mental ill health will affect one in four in the population and those working in the NHS are certainly not immune from this. Indeed, the very work our frontline staff, managers and leaders undertake every day may make existing mental health problems worse and indeed may bring work-related mental health problems to some NHS workers simply because of the work they do. The NHS as an employer must become better at supporting staff with mental ill health and must lessen the mental health impact on NHS staff resulting from the work they do. Recognising mental health in our workforce and supporting those with mental ill health must define the NHS as an employer. People with mental ill health frequently suffer discrimination and this exacerbates their condition. Occasionally, and tragically, we hear news of suicide from within our NHS workforce and those undergoing education and training in the NHS.

As a healthcare organisation delivering care to the people of this country, we should never forget that the care-givers, the people on the front line of the NHS, also need care and support.

Distress, stress, burnout, self-harm and ultimately, the loss of life due to these stressors are unacceptable. Across the UK this has been recognised in the Government review, *Thriving at Work* (2017) which summarised the evidence and made a case for improvements in workplace mental wellbeing.[152] We see this as a seminal report whose recommendations must be implemented in support of learners and NHS staff.

It is unclear to what extent increasing pressure on the NHS is contributing to mental ill health within the NHS workforce. While there are undoubtedly many people enjoying a happy working life, reports of distress in the workforce abound within academic literature, social media and the wider press. It would appear there is much work to be done. It is time to stop asking 'should we?' and instead question 'how are we going to do this and when?'

5.3 Key questions

In this report, we are seeking to answer four key questions relating to the mental wellbeing of NHS staff:

1. What are the factors that can cause or worsen mental ill health in the workplace?
2. Who is at highest risk and what does the evidence tell us about how to address this?
3. How can we best support our staff as they transition between the different stages of their lives and careers?
4. What lessons can we learn from the evidence about good practices that can positively influence an individual's ability to thrive during their working life?

The value of tea and teamwork
Social media support provided by the Tea and Empathy group

The Tea and Empathy group is a national peer-to-peer support network aiming to foster a compassionate and supportive atmosphere throughout the NHS. Its Facebook home, created in 2016, now has nearly 7,000 members, with a purpose of providing non-judgmental, informal listening and emotional support to colleagues across the health service who are finding work difficult.

Tea and Empathy aims to reduce stigma and signpost to appropriate services where needed. Membership has grown steadily with regional sub-groups being established across the UK. The group aims to keep Facebook discussions in the public domain wherever possible but some topics require the use of private groups on the site. Private group discussions include issues such as support for doctors with addiction problems or those who have made a mistake at work.

Devon-based psychiatrist Dr Phyllida Roe, a founder member of Tea and Empathy, says: *"When people are really in trouble they forget what support systems are out there. They may feel panicked, isolated or alone. They may be fearful of being found out, being seen as the 'weak' or 'stupid' one, or as someone who cannot cope; we tend to work in a culture that is stigmatising. An important role of Tea and Empathy is to remind people of these support systems and we have a massive list of where people can go for help. Part of the reason why people might not be aware of these support systems is that it all comes in a ten-minute brain dump during induction. At this point they probably do not imagine they will ever need these systems*.

"We are now a substantial community, we do not advertise as it is all word-of-mouth. Occasionally when life is horrible for me I ask for jokes and cute pictures and a community responds which is very comforting. You will see posts made by members at all levels and depths, some will be short, some will be long, often where people have got to a point in their life where they need validation or support.

"We recently had a post on Tea and Empathy saying 'suppose the NHS was adequately funded, would we still get burnout?' The discussion is on the public pages and has had more than 50 responses so far. Of course we would still get burnout but members talked about the sort of things that would make a difference (and help prevent burnout): issues such as better supervision, better education and the opportunity to have some kind of debriefing. We should be aiming for a system where signs of burnout are spotted early. We need a culture that recognises this and rather than apportioning blame to people for being 'weak', seeks to look at people's lives and how they can be best supported. Even if people miss the humane factor in all of this, burnout costs the NHS money, it is an expensive problem."

For further information, visit the Tea and Empathy site: https://www.facebook.com/groups/1215686978446877/

5.4 The system

The NHS staff survey[153] is an annual survey of the opinions of all NHS staff with key questions on staff wellbeing. The 2017 survey reported that slightly more than one in three (38.4%) of the workforce had felt unwell due to work-related stress and one in two (52.9%) staff had attended work despite feeling unwell because they felt under pressure from their manager, colleagues or themselves to do so. The survey also reported increasing levels of BAME staff reporting discrimination.

The Royal College of Physicians[154] has reported that 84% of doctors believe that the NHS workforce is 'demoralised' and 80% are worried about the ability of their service to deliver safe patient care over the next 12 months.[154] The Royal College of Nursing[155] similarly reported almost half (49%) of nursing staff have gone to work when unwell with stress and mental ill health, and 79% felt that staffing levels at their place of work were insufficient to meet patient needs. More than a quarter of nurses (27%) have experienced physical abuse from patients or relatives in the last 12 months, and 68% have experienced verbal abuse from the same groups. About one in three nursing staff (31%) say that they have experienced bullying or harassment from colleagues in the last 12 months, with Black African/Caribbean and disabled nursing staff more likely to report this than other staff. These figures are much higher than in the more robust NHS staff survey and therefore there is some caution regarding interpretation but remain concerning even if there is possibly some element of selection bias.

The Point of Care Foundation's report, *Behind Closed Doors,* said that increased sensitivity to stress and burnout was the result of staff suffering a state of 'moral distress'; that they were prevented, by system pressures, from being psychologically, emotionally and physically able to engage with patients, families and colleagues.[156] In recognising the increased service demands on teams, the report said there was evidence that staff are working unpaid additional hours, working without adequate rest periods and sometimes failing to have their basic human needs met in order to place patient care first.[95,139,157,158] While it is likely that clinicians will often want to complete an episode of care or ensure that they know what has happened with a particular patient, and such

altruism is valued, it is concerning that this is now often simply due to workload and capacity issues and has become normalised rather than voluntary.

As the NHS re-models its services and transforms the workforce, new roles are emerging such as advanced clinical practitioners and nursing associates to support gaps in other workforce roles. This offers opportunities for career development and progression for staff and often a more appropriate team structure and skill-mix in delivering patient care. This can lead however to increased intensity of work for those that are not completing some of their easier tasks and there is early evidence of stress relating to the increased burden of these roles on the individual.[159]

That reports of stress, exhaustion, burnout and self-harm are rising is itself worrying but an additional concern is that this might lead to an increase in staff suicide. Thankfully the data tells us that this is, thus far, not the case[160] but this should not be a cause for complacency. Workforce-related stress and related mental ill health must be addressed and suicide in our workforce must be reduced further. It is suggested that public health campaigns generally in society have been effective in reducing overall numbers of deaths from suicide and rates have fallen consistently over the last three years. This a complex field and other societal changes will also impact. There is though concerning evidence that suggests some NHS professional groups are at heightened risk of death by suicide. In the latest Office for National Statistics report on suicide deaths by occupation it was highlighted that deaths in female healthcare workers were 24% higher than the national average - this is explained by high suicide risk among female nurses.[161] In addition, after concerns were raised by the Association of Ambulance Chief Executives, research found that male paramedics had a higher risk of death by suicide than the average population, although the size of that effect could not be accurately quantified due to the low absolute numbers.[162]

As stated in the Foreword, our view is clear: one death by suicide is one too many.

More research is needed into the causes of distress, burnout, self-harm and suicide in healthcare

and into effective system changes and individual interventions. We need to fully understand the professions that are most at risk, such as female nurses and male paramedics. Such evidence will help inform targeted, specific interventions to promote wellbeing and reduce the risk of suicide. We must be able to equip everyone with the prevention skills that are available. The Commission saw the research carried out for the Association of Ambulance Chief Executives into suicide among ambulance staff, and as a result of the worrying findings, HEE has now commissioned follow-on research to explore the issues arising further.

The Commission heard significant evidence about the emotional labour needed by those who are working or learning in the NHS. As the Commission advanced, we began to hear much more from staff about the everyday pressures arising from relationship stress, family, children and the impact of caring responsibilities outside of work. We heard about the impact of financial worries and social pressures; how staff felt that their commitment to the NHS often resulted in a fracture to vital social support, their hobbies and activities all of which nurture wellbeing. Some felt the need to keep their work and associated emotions away from family and friends, others talked about the acute emotional pain of isolation and feeling estranged from the support of family, friends and place. The overlaying of the emotional labour of work on top of escalating everyday life pressures presents a 'double burden' that for some is too much.

The Commission heard about the acute sense of loss felt by some staff at what they saw as the erosion of the NHS as a family - a community and a place where, in the margins of work, you could share feelings and decompress from an 'event' together. With that loss has come an erosion of all the health-giving benefits of human contact, reciprocation, belonging, identity, security and social support. This is further compounded by what seemed to be a heightened sense of stigma and self-stigma expressed by those who care, that the Commission heard much about. This stigma effect heightened barriers to accessing support and services. A distinction was seen between staff who were overwhelmed with distress and staff who were presenting mental illness. Both can be equally

impactful and potentially dangerous but those in distress did not necessarily identify the need for mental health services but were estranged from emotional support.

Where stigma concerning mental health issues among the general population is being addressed, and we see progress, but much more could be done within the NHS for its staff. The Commission found the impact of stigma to be deep-seated and profound. The trust and confidence needed in ensuring confidentiality was expressed by some staff as a barrier to seeking work-based support. If general stigma reduction remains the objective, the Commission feels it important to break down barriers to emotional support and enhance the sense of community to respond immediately to the presenting situation. An example of this approach external to the NHS is seen in Samaritans' Network Rail partnership[163] where the industry has been supported to develop its role and responsibility in staff emotional support and suicide prevention through culture change, releasing the capacity of the industry and the general public to care and act.

5.5 Current support

"At a time when there is a national focus on productivity the inescapable conclusion is that it is massively in the interest of both employers and Government to prioritise and invest far more in improving mental health."[152]

Employers' recognition of the impacts of mental ill health have been growing over the past ten years. In 2009 the Boorman Report made a number of recommendations to address emerging issues with mental wellbeing.[114] There has since been a steady rise in the availability of guidance, toolkits and quality benchmarks that have encouraged employers to respond to the increasing profile of mental wellbeing at work. This has been encouraged by the advent of a national Commissioning for Quality and Innovation (CQUIN).[164] Enhancement of this CQUIN would strengthen levers to encourage employers to support staff mental wellbeing.

The Government review *Thriving at Work* (2017) summarised the evidence and made a case for improvements in workplace mental wellbeing.[152]

The review highlighted a continuum of mental wellbeing for all and that people fluctuate between thriving in work, presenteeism and absenteeism. The report highlighted that:

- The cost of mental ill health in the NHS workforce equates to between £1,794 to £2,174 per employee per year [165]
- The return on investment of workplace mental health interventions is £4.20 for every £1 spent
- 15% of people at work have symptoms of an existing mental health condition
- Those with mental health conditions lose their jobs at twice the rate of those without mental health conditions
- There are particular professional groups within the NHS that are at significantly greater risk of stress and trauma.

Thriving at Work was a call to action with public services expected to lead the way for the UK economy in creating workplaces where individuals in employment, including those with mental ill health, are supported at work. In response, a Health and Wellbeing Framework has recently been published for the NHS.[166] The framework (*see 'Useful Resources'*) has brought together good practice, research and insights to support NHS organisations to improve staff health and wellbeing. It is an interactive document that makes the case for staff health and wellbeing, sets out clear actionable steps for each of the 14 areas and includes guidance on how organisations can plan and deliver a staff health and wellbeing plan. Its value will depend of course on the success of implementation.

The Commission concludes there is a clear economic case for investment in the mental wellbeing of NHS staff.

5.6 Current challenges

"Several factors related to the occupation, the organisation and the individual appear to increase the risk of mental health problems in doctors. The most common causes are high perceived workload, the growing intensity and complexity of the work, rapid change within healthcare, low control and support and personal experiences of bullying and harassment."

Society of Occupational Medicine report (2018), What could make a difference to the mental health of UK doctors? [168]

5.6.1 Data collection

The Commission has identified that there is insufficient collection, analysis and action on data regarding the mental wellbeing of the workforce. For example, doctors have low recorded levels of sickness absence (1.32%) and healthcare assistants have high levels (6.25%).[169] We need to know more about factors that underpin such a difference - could this be due to a physician feeling compelled to stay with a sick patient rather than attending to their own needs [170] or the influence of socio-economic status? The Health and Wellbeing Framework[166] encourages using different research methods to better understand the data obtained. Essential to the success of this approach will be agreements to collate and share information across the sector.[166] There are various tools/frameworks available to support employers to better understand the mental wellbeing of their workforce and these should be more widely adopted.

5.6.2 Increasing the breadth of evidence

The current evidence on mental wellbeing is dominated by literature relating to medical careers. While there is no doubt that there are difficulties experienced by doctors, we must be careful that this does not completely obscure the problems encountered by other professional groups. When considering this perspective in the context of the whole workforce, any imbalance in representation could reinforce perceptions of hierarchy and inequality between professional r oles and the value that is placed on members of certain professions or not. A key recommendation from *Thriving at Work* was that there should be much greater focus given to professional groups that are deemed to be at high risk. Evidence presented to the Commission suggests that this would include female nurses, paramedics and vulnerable groups such as BAME healthcare staff, but further research is required to better understand high risk groups and interventions targeted to their group specific risks.

Caring for the carers
Mental wellbeing support provided by the Royal College of Nursing

Healthy Workplace, Healthy You is a Royal College of Nursing (RCN) initiative to support employers and RCN representatives to improve working environments. It also supports nursing professionals to lead healthy lifestyles so they can maintain both physical and mental wellbeing.

Healthy Workplace uses a toolkit, divided into five domains: work-life balance, dignity at work, health and safety at work, job design, and learning and development in the workplace. This provides an organisational health check and identifies areas for improvement, with links to sources of support for making the changes necessary.

Healthy You encourages nursing professionals to take the time to consider factors that might impact upon their own health, focusing on the importance of self-care. The RCN encourages members to complete a self-assessment worksheet and use various web resources to help prevent and manage physical and emotional stress.

In line with this Healthy You approach, the RCN's member support services team offer a number of services to promote wellbeing: counselling, peer support, careers advice, welfare advice, immigration advice, and support during financial hardship.

Tanja Koch co-manages the organisation's free and confidential counselling service, helping members deal with challenging, emotional issues. *"Individuals come to us when they are unable to cope, their day-to-day functioning has been impaired, and risk factors may be present,"* she says. *"A common theme is that individuals push themselves too hard while they assume they 'should cope'. Feelings of guilt and shame, fear of letting others down,* *or being reprimanded adds to their already increased stress and anxiety levels. There can be a tendency not to address psychological symptoms and physical manifestations of stress and anxiety or work-life balance issues. This leaves members of the nursing community prone to work errors, injury, accidents, sickness absence, burnout and a desire to leave the nursing/caring profession - ultimately risking patient safety. Students particularly worry about competency sign-offs from their mentors and would rather not rock the boat.*

"Our counselling service aims to ensure that individuals in the nursing community are equipped to handle the pressures of the modern nursing environment. Through self-care and self-compassion, individuals can enjoy better mental and physical wellbeing, resulting in a better quality of life for them and their families and of course excellent patient care."

The counselling service provides six sessions delivered over the phone and members can access the service whether their issues are related to their studies, placement, work or personal life.

Tanja adds: *"A constant theme is that nurses seem to require 'permission' to look after themselves, whether that permission is given by others or themselves.167 But why would you need to give permission? I believe self-care and improving resilience needs to be massaged into everyone's academic learning, their workplace and clinical supervision. How can we encourage everyone to take out a moment in the morning or at the end of the day and say 'am I feeling OK?' "*

For further information visit: www.rcn.org.uk/healthy-workplace

5.6.3 Workforce re-modelling

It has been Government and NHS policy for many years to move care closer to home. The emphasis of new models of care is on delivering more community-based care; when fully implemented, this will change the way that many members of our workforce deliver care.[171] There are implications for how we support the mental wellbeing of an increasingly mobile and more remote and potentially isolated NHS and care workforce. We have discussed earlier in this chapter the issues facing ambulance staff and paramedics and issues of isolation and lack of contact with teams and bases are already a feature of some community nursing and midwifery services which may require extra support and different interventions.

5.6.4 Work-life transitions

There are a number of transition points as an individual progresses through their studies and career. These could include the initial move into the workplace, new roles, new jobs, the effect on staff of workforce transformation, the process as a member of staff transitions from pre-skilling, through up-skilling and possibly re-skilling, changes to personal circumstances and ultimately, retirement. We need to know more about how we can best prevent 'falls outs' during these periods of uncertainty and instability, with inherent risks for mental wellbeing. This is particularly important as people ebb and flow between educational settings and workplaces and through the different stages of their personal lives.

5.6.5 Social media

Learning institutions and NHS workplaces are frequently using social media platforms to reach large and remote staff groups, with many organisations also capitalising on the fact that use can boost engagement with external groups and the public. As more staff are encouraged to use social media during their daily working lives it is important to consider the implications of this on mental health and wellbeing.

A study on registered nurses in the UK and Italy indicated that online exposure and online activity was starting to blur the boundaries between professional and personal lives.[172] It is highly likely that this is the case across most professional groups.

From time to time, cases of clinical practice attract media attention, which in turn can attract social media commentary and occasionally and sadly, online shaming/personal insults, all of which can be extremely distressing for staff.

This increased accessibility to our staff poses new risks that can extend far beyond the boundaries of the traditional workplace. It is important that support processes are examined in the light of the fast pace of the online environment and that staff are given the tools to manage adverse events which may occur during their personal lives. The Commission envisages the Workforce Wellbeing Guardian community seeing this as a priority in understanding the external factors that impact the wellbeing of NHS staff.

Conversely, increased connectivity can also yield benefits for staff. Private peer-to-peer groups are rising in popularity and are proposed by their members as a forum for reaching out to safely discuss concerns and offer support. Some groups centre upon workplace stresses while others are specifically focused around issues such as bullying and harassment. Notable examples include the #WeNurses Twitter community, which connects nurses with the objective of sharing information, ideas, knowledge and support in order to improve patient care. The *Free Open Access Medical Education* (FOAMed) movement - which is an active community worldwide - comprises medical education blogs, websites, Twitter discussions, podcasts and videos. Much of the content is related to urgent and emergency care and can vary from the minutiae of procedural techniques to the emotional impact of working in healthcare. The online discussions that result can form a type of reflective practice and may help individuals connect with others through shared experience, where in some cases in the middle of a busy shift it might be difficult to speak with colleagues directly.

While such initiatives are commendable, the concern remains that if the only option is external social media in sharing this narrative, a valuable opportunity is being missed for learning internally within organisations. In view of this it is worth

considering how we can learn from the current staff use of social media to support relationships and create a culture of trust. Evidence should be sought to support this endeavour.

5.6.6 Impact of errors

Much work has been undertaken into building a culture of disclosure, speaking-up and learning from 'honest mistakes' rather than blame. Professor Sir Norman Williams has been leading an inquiry into gross negligence manslaughter as is now applied to healthcare workers.

Being involved in and witnessing errors contributes to mental ill health and is a prime cause of stress in the workplace.[173] Because of this, the people who have made the error are often referred to as the second victim.[174] Some refer to the overall clinical leader or educator, or the families and friends of healthcare professionals, as the third victim. Investigations can be lengthy and simple mistakes can often be felt to threaten a clinical professional's career. Although there is much evidence relating to this topic, further work is required to more fully understand the issues involved.

5.6.7 Burnout

The Commission has heard stories of where constant pressure and day-to-day stress has led to situations of staff 'burnout'.

The Society of Occupational Medicine states that burnout is by far the most commonly used measure of doctors' mental health.[168] Burnout can be defined as a: *"psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment. The significance of this three-dimensional model is that it clearly places the individual stress experience within a social context and involves the person's conception of both self and others."*[175]

In a European Union-funded study of 33,659 European nurses, including 2,918 nurses practising

in 46 English NHS hospitals, nurses in England ranked 11 out of 12 for high burnout scores. They also ranked unfavourably compared to many other countries in Europe on dimensions such as adequacy of staffing and resources, and the quality of the work environment, factors that may suggest why nurses in NHS hospitals may suffer from high burnout. [176,177]

In midwifery, the *Work, Health and Emotional Lives of Midwives in the United Kingdom* study (WHELM),[178] 83% of midwives said they felt personal burnout, with 67% attributing burnout to the workplace. The State of Maternity Services report (2018) indicates that in England there is a current shortage of 3,500 midwives due to high attrition rates. The WHELM study found that 66% of the surveyed midwives stated that they had considered leaving the profession within the last six months, with the most common reasons cited being poor staffing levels (60%) and dissatisfaction with the quality of care they were able to deliver (52%).

"Many midwives are working with a lack of staff, lack of breaks, lack of support and not able to care for themselves. I just feel broken and it devastates me to admit this. No matter how many times I keep telling myself it will get better and it won't always be this bad, nothing improves."

Blog post of anonymous midwife [179]

5.7 The workforce

"Progress is happening but nowhere is really demonstrating a mentally healthy workplace. Every part of the system needs to be thinking 'mental health'."

Professor Louis Appleby, personal communication.

A team's ability to create an environment where they can function well together and provide high quality care is dependent upon the relationships formed between the people who make up that team. Staff talk about a local work group climate with good teams as a 'family at work'.[180] Social relationships are central to good mental wellbeing and yet we continue to see them compromised by the pressures of daily health care delivery. Staff are

routinely moved around hospitals from their normal team and workplaces in order to meet changes in demands in other parts of the system. The working arrangements of paramedics for example, can make them feel socially isolated during shifts. This continual state of flux is unsettling and inhibits the ability to form relationships resulting in poor morale and isolation from peer groups. When staff do not share a bond with their colleagues, they can lose the ability to interact freely, to know when someone is struggling and be available for support. Staff can feel isolated and find it difficult to raise concerns.

The relationship between managers and staff is seen as a key influence in manifesting employees' mental wellbeing yet we continue to hear damaging reports of bullying and undermining in the workplace. NHS staff survey results demonstrated that 24.3% of staff experienced harassment, bullying and abuse from colleagues in 2017.[153] A study of obstetrics and gynaecology consultants reported the impacts of bullying being sleep disturbance, lack of confidence, depression and suicidal thoughts.[181] In this regard we note the innovation from the Royal College of Obstetricians and Gynaecologists on workplace behaviours advisors in addressing undermining and bullying behaviour. Again, more research is needed to fully understand the prevalence, causes and actions that can be taken to address this issue.

"I think that you should feel safe and I don't just mean physically safe. You should feel psychologically safe and that it is an atmosphere where bullying is absolutely not taken at all."

Dame Carol Black, Principal, Newnham College, Cambridge, Association of British Insurers Mental Health Conference 2017.

As stated earlier in the report, there are now four generational groups working in the NHS. As managers and leaders are more likely to come from older generational groups, we need to see more research into how different generation managers and leaders support, help and get the most out of the people they manage.

Many of the contributing factors towards poor mental wellbeing in NHS staff are not different to those faced by the general population. Financial pressures, balancing work and home responsibilities, and the breakdown of existing relationships are cited as causes.[152] An open dialogue and constructive support from the line manager can help alleviate mental ill health. The *Thriving at Work* report[152] found just under one in four managers (24%) were trained to support mental wellbeing at work. We expect this will have increased following recent workplace initiatives and would welcome further evidence from across NHS organisations. Having trained managers undoubtedly reduces the impact of stigma attached to mental ill health. Stigma[168] is also being challenged in many high-profile campaigns, and hearteningly some of these have been raised by the staff themselves, such as *#CrazySocks4Docs*, raising awareness of doctors' mental wellbeing. A commendable campaign driven by staff, for staff. Unfortunately, the literature suggests that issues relating to cultural barriers towards mental ill health still seem to be pervasive within certain groups, such as doctors.[137]

The Commission heard from one organisation, West Midlands Ambulance Service NHS Foundation Trust, about a comprehensive support system that has been put in place for their workforce. It is an organisation at full employment, with staff absence continually reducing, and with staff and patient surveys recording high satisfaction scores. With involvement and support from the trade unions, West Midlands Ambulance Service has helped introduce a number of measures to improve staff wellbeing, including a staff health and wellbeing group, quiet rooms, access to early interventions, and post-incident support.

Nathan Hudson, Emergency Services Operations Delivery Director for West Midlands Ambulance Service told the Commission: *"We always have debriefing after events. We take staff away and allow them time to come to terms with what has happened and, if needed, they can go home, we put it in the hands of individuals. We look after our staff and respect the fact they need to have meal breaks and have homes to go to at the end of the shift. The key is changing the environment in which our staff work rather than changing our staff. One of the big things for our staff is about finishing on time and getting a break. Surveys show 85% of my staff leave within 15 minutes of their finishing time."*

5.8 Workforce and protected characteristics

In the Workforce Wellbeing Guardian principle eight we state that:

The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010.

Societal research suggests an association between BAME status and lower subjective wellbeing, secondary to experience of exclusion, racism and discrimination.[182] Findings suggest that rather than being an exemplar for staff wellbeing, the NHS, one of the biggest employers in Europe, illuminates the drivers for differences in wellbeing between different ethnic groups. It has been highlighted that inequality impacts on the effective and efficient running of the NHS, including on quality of care received by patients.[183,184] If the NHS gets it right for staff members with protected characteristics, then it will get things right for the wider workforce.

It is known that BAME staff are more likely to face disciplinary action than their white counterparts, and this is seen across the workforce.[183,184] Experiences of racism and discrimination can be linked with work-related stress and there is a link between stress, burnout and mental distress.[185] Further support should be directed towards individuals under investigation. There has been evidence of a gender and ethnicity pay gap,[186] differential attainment, including a difference also seen between UK white graduates and UK BAME graduates in exam performance.[187] White staff are more likely to access continuing professional development opportunities and non-mandatory training opportunities.

The NHS recruits a significant number of clinical staff and learners from the European Economic Area (EEA) and non-EEA countries, some through training programmes on earn-learn and return initiatives and some on substantive contracts.

However, we found that these staff are not always adequately inducted and supported in the workplace. International medical graduates for example have been noted to be a risk factor for presentation with mental health issues to the NHS Practitioner Health Programme.[138]

Induction needs to be improved for staff from abroad, and the NHS needs to demonstrate its wellbeing credentials to this highly valued element of our workforce by working with local communities to assist transition. The Workforce Race Equality Standard continues to collect data from trusts and arm's-lengths bodies on equality and diversity and in November 2018 held a forum with wider stakeholders across the NHS in terms of tackling these issues. Further co-operation is required among NHS stakeholders to support their BAME workforce and increase BAME representation at senior management levels of the NHS to reflect its workforce. This is important to the application of the Workforce Wellbeing Guardian principle six.

There are over 100,000 NHS staff who identify as LGBT+.[188] The Commission has heard of a wide disparity of experience for these staff. While there are five NHS trusts ranked within the Stonewall Top 100 most inclusive employers 2018,[189] it is reported that in some other places of work LGBT+ individuals face hostility and discrimination that severely impacts their mental health. Research carried out by Stonewall has found that many of these staff hide their sexual orientation, for fear of bullying.

"Lesbian, gay and bisexual people working in the NHS want the same as other staff - to work in a safe environment where they can perform to the best of their ability and be valued for their hard work. But the fear of discrimination felt by many gay employees means that extra work is needed by their employers to help them feel safe and able to perform... lesbian, gay and bisexual staff who can be open about their sexual orientation at work are more likely to enjoy going to work, are more confident and are ultimately more productive."

Stonewall report for the NHS[190]

The Stonewall report, *Unhealthy Attitudes,* found that almost a quarter of NHS staff have heard their colleagues make negative comments about LGBT+ people.[191] Whether these comments are made regarding LGBT+ patients or about colleagues, the effect of LGBT+ NHS staff and learners hearing these comments can be that the workplace becomes a more difficult environment in which to function.

A specific issue pertinent to LGBT+ NHS staff and learners is the nature of rotational placements, and the lack of permanent team structure in many specialties. The effect is that LGBT+ individuals constantly have to think about whether, and how, to 'come out' or disclose their orientation (or feel they must conceal it) with each new group that they work with. The repeated stressor of having to consider this process - even when a team is positive and accepting - can have a negative impact on mental health.

More research is needed into the specific experiences of trans-identifying people working and learning within the NHS. The Commission has heard of the difficulties encountered by trans-individuals when there is a lack of gender-neutral changing rooms - this may be highly problematic for someone whose work requires that they change into theatre scrubs or uniform.

The Commission recognises that more needs to be done for the NHS to lead the way in becoming more inclusive. We advocate for each employer to have a transparent and public policy regarding LGBT+ issues, and a zero tolerance policy towards discrimination. Every employer should be openly supportive of grassroots movements to promote equality and diversity. It is important that this is advocated for at all levels of NHS leadership. When we get things right for patients, we are more likely to get things right for NHS staff.

The Rainbow NHS badge project, launched at Guy's and St Thomas' NHS Foundation Trust, is one example of a grassroots movement to promote equality and inclusion. Wearers of the badge promise to be someone whom patients can speak to openly about issues of sexuality and gender, and provide information about sources of support if needed. The secondary effect is that LGBT+ identifying staff see symbols and behaviours

indicating that they are welcomed and accepted - an important first step to promote a positive message of inclusion. It is hoped that the Rainbow NHS badge project will soon roll out across the NHS.

Within the NHS, among staff, patients, carers and communities, there is a rich and growing diversity of faiths and beliefs.[192] The nature of the service means that people, at the most profound moments in their lives are brought to grapple with hope, fear, loneliness, compassion and other powerful emotions. In these experiences, people draw on, are strengthened, challenged or struggle with their own view of the world and their place within it - what we might call their faiths and beliefs. For some, these faiths and beliefs also represent the core of their identity, whether based on membership of a particular religion or faith group, or on humanist principles, or on philosophical beliefs and life-stances of a different nature. It is also important to recall that each individual's identity is multi-faceted and may well include a number of protected characteristics, some of which may be in tension with each other.

The NHS has long recognised the importance of seeking to meet the expressed personal wellbeing, spiritual and religious needs of patients, staff and service users. While support may have historically been focused on established religious groups, faiths and denominations, all staff and patients and their families may still require personal wellbeing support, for example in times of crisis, whether or not they hold a particular religious affiliation. Much of this care is expressed through the work of NHS chaplains, although all staff may be brought face-to-face with these issues, through their own care of patients and their responsibilities to each other.

For NHS leaders, it is also crucial that they recognise the significance of people's faiths and beliefs - whether staff, patients or carers - in the way that services are configured, in the way that operational practices and systems take account of those needs, and that the wellbeing of staff, not solely of patients and families, includes a recognition of the 'fundamental elements of the human spirit' which enable staff to do the work which they do with insight and compassion, as well as with technical expertise.

5.9 Interventions

It has been recently suggested, from research regarding doctors, that interventions for mental wellbeing can be categorised into primary, secondary and tertiary.[193] Primary interventions seek to remove the source of distress, secondary aim to increase the individual's capacity for coping, and tertiary indicates interventions that promote recovery once an individual has become ill.

While it is proposed that primary interventions yield the greatest effect on wellbeing, it is also acknowledged that they can be the most difficult to achieve due to the organisational adjustment often required to achieve change. This can be both costly and time consuming, requiring considerable commitment from managers, colleagues and those responsible for the design of organisational systems. Interventions can include alterations to working conditions, policies and increased control over job specification.

Secondary interventions, such as mindfulness or resilience training, are found to be of benefit but have the limitation of being useful to only those that are predisposed towards the specific technique. Interventions that are centred upon individual preference imply that a range of options would be needed, indicating a 'toolbox' style approach.

Tertiary schemes aid those that have suffered from mental ill health to rehabilitate and are usually supported by occupational health services.

Recently we have seen the addition of schemes that specifically support doctors suffering mental ill health, such as the Practitioner Health Programme. Such schemes recognise the fact that doctors, in particular, experience difficulties accessing healthcare for mental health concerns due to a number of factors relating to their position in the healthcare system. The Commission has heard evidence that this is also the case for other professional groups such as psychologists and mental health nurses. Further work must be completed to identify staff with occupational barriers that prevent them from accessing support.

The Commission has witnessed many examples of forward-looking organisations that have sought to implement interventions to improve the mental wellbeing of staff. While this is commendable, we must ensure that support and guidance is offered to organisations in implementing multi-level interventions in an integrated manner. This will help to ensure that the impact of primary interventions is optimised and helps avoid the perception of interventions being tokenistic.

5.9.1 Peer support

Peer-to-peer support methods appear to be successful in addressing mental wellbeing issues at work.[194] This helps develop a strong team ethos within the NHS and demonstrates the importance to individuals of offering support to one another through times of mental ill health. Both formal and informal[194] methods have been used and have varied from organised and structured hospital-based sessions to staff-led social media networks.

The positive evidence base surrounding the more formal approaches is growing and an increasing number of workplaces are adopting such methods. One such approach is Schwartz Rounds® - monthly facilitated group sessions based upon an empathetic sharing of staff experiences open to all professions.[195] A recent National Institute for Health Research evaluation has demonstrated their effect, with poor staff wellbeing halving for Rounds attendees compared to a control group. Interventions that require staff to be available in one place may have limited potential when staff are dispersed across a wide geography, but solutions such as pop-up Schwartz Rounds and the use of technology to connect remote staff are being explored.

The NHS needs to recognise the effect and stigma associated with being involved in traumatic healthcare-related events, not least 'significant events' across the whole healthcare workforce.

5.9.2 Self-care

Universities are recognising that medical staff should be taught methods by which they can recognise signs of their own mental ill health and

seek support.[197] The intention is that its legacy will be fully realised when staff enter the workplace and continue through their careers. For maximum benefit we need to see this work expanded to other professional disciplines and capture those that are already in the workplace. We have seen evidence from primary care that interventions can make a difference, with reports suggesting that self-care support approaches can improve job satisfaction, quality of life and compassion.[198] Other studies have revealed that interventions can also reduce symptoms of stress.[199]

The Commission heard about various approaches to supported self-care that were well received by staff. One panel meeting was advised that a whole system approach was needed, with the following point being made (on an anonymous basis):
"Improving the health and wellbeing of learners and staff has to be a cradle-to-grave, whole system approach. All of the evidence that we have seen in the public, private and education sectors is that there is no single intervention that is going to make this better. If you do not address the system issues then in the bluntest terms you can't yoga your way out of bad management and poor rota design. Similarly training people to be resilient in a system that is failing is not a way of solving the problem. There is therefore a real need for coherent, systematic and sustained action if we are to change the current picture."

5.10 Impact on patient care

Reported system pressures suggest that staff working in the NHS are at increased risk of stress, burnout and mental ill health. In turn, there is evidence this can lead to increased risks and poor experiences for patients. The chronic symptoms of sustained stress and mental ill health can affect the behaviours of staff and their relationships with colleagues and patients. Long shifts are associated with patient dissatisfaction and staffing shortages can mean that staff are not able to perform necessary tasks for patients such as changing intravenous dressings.[200,201] When staff are emotionally and physically exhausted the evidence tells us that there is an increased risk of errors which can ultimately affect patient outcomes.[202]

In 2013 Sir Robert Francis conducted a detailed public inquiry into the Mid Staffordshire NHS Foundation Trust.[203] There has been a huge amount of work since the published report to ensure that patient care and safety is paramount. The report stressed the need to protect compassion and empathy in our workforce. Evidence suggests that stress and burnout can significantly affect this and we have seen this termed as 'compassion fatigue'.[204] The vulnerability of patients when compassion and empathy are eroded is a significant cause for concern. Conversely, what we have learned is that when staff are happy and engaged in their work there are numerous benefits to patients. These range from increased satisfaction to reductions in infection rates and lower standardised mortality figures.[205,206]

Given that the positive mental wellbeing of staff has been shown to improve both patient experience and patient safety, there is a case for patients to be involved in designing systems to support staff wellbeing and to understand the importance of staff wellbeing.

5.11 Supporting our staff - summary

The need to work together, across systems and educational boundaries is imperative. If there is a discordant level of support between different workplaces and educational settings, this is likely to leave students and staff more vulnerable to the effects of mental ill health. We need to continue to make the case for the collation of data and sharing of good practices in order to capitalise on the output of the work of the Commission.

Shining a light on wellbeing in the emergency services
Research by Mind into mental health issues faced by ambulance personnel

Research carried out by the mental health charity Mind has found that members of the emergency services are more at risk of experiencing mental ill health than the general population but are less likely to seek support.

The findings have led to the development of the Blue Light programme aimed at improving the mental health of emergency services personnel in England and Wales. This programme focuses on five areas: tackling stigma; embedding workplace wellbeing; increasing resilience; providing targeted information and support; and improving access to mental health support.

The research to inform the programme was carried out in 2014-15. It attracted 1,352 responses from ambulance service staff. Findings from the ambulance service included:

- 91% of ambulance personnel have experienced stress, low mood or mental ill health while working for the ambulance service
- More than half of ambulance personnel have lived experience of mental ill health
- Ambulance personnel are nearly three times as likely to identify problems at work as the main cause of their mental ill health - compared to the general workforce population
- Excessive workload (68%), pressure from management (63%), long hours (60%), and changing shift patterns (56%) were identified as triggers more often than exposure to traumatic incidents (52%)
- Ambulance personnel were more negative about the impact of their role on their mental wellbeing than personnel in the police and fire services

- As with other services, ambulance personnel work hard to prevent their mental ill health affecting their performance, but this comes at a large personal cost (including relationship breakdown and effects on physical health)
- 80% of ambulance personnel thought their organisation did not encourage them to talk about mental health - this is much more negative than the general workforce population (45%)
- 45% thought colleagues would be treated differently (in a negative way) if they disclosed a mental health problem at work
- 56% of ambulance personnel were not aware of their organisation's support
- Ambulance personnel were most likely to seek support from their colleagues

Faye McGuinness, Head of Workplace Wellbeing Programmes (Strategy and Development) at Mind, said: *"It is not a question of whether we should be recruiting more 'resilient' people into the emergency services. What we need to do is to make sure that the organisations that people are coming into are set up in a way that can support people properly. Staff joining ambulance trusts say they receive training about their role, but they do not receive any training or information about how to look after their own mental health. Some say they might get a two-hour general awareness session about mental health but that's it. Mind also carried out some research with new recruits who said to us that they do not feel prepared for what they are going into and that the thought of their 'first job' can be very scary."*

Further information on the Blue Light programme: https://www.mind.org.uk/news-campaigns/campaigns/bluelight/

5.12 Recommendations

For most of the 1.4 million people who work in the NHS, there is no other job that would bring the satisfaction they get from working with great colleagues and from caring and supporting patients and their families. But, the impact on our staff of what they see and what they experience in the course of their work cannot be dismissed lightly. We ask in this report, *'who cares for the people who care for the nation's health?'* and we say that we must improve the way in which we look after ourselves and our colleagues, so they are better placed to look after the needs of their patients. This chapter's recommendations aim to strengthen and make more relevant the support that already exists for staff but will also point to ways in which new support can be provided. Our recommendations will also aim to make the mental wellbeing of NHS staff something that is uppermost in the minds of our staff and their work colleagues and something that forms a new and regular dialogue between 'ward and board'.

Recommendation 19:

NHS staff and learners are exposed to the highs and lows of humanity and the human condition on an hour-by-hour basis. Dealing with these is included in current curricula. Where additional training and support is provided it is reported to be beneficial and the Commission has heard of the considerable value placed on good peer support. Frontline staff describe themselves as having relatively few opportunities to process their experience with colleagues - team meetings are infrequent and task focused, and psychologically safe and confidential spaces such as staff cafeterias and rest areas where they could spend time with one another informally are no longer available in most facilities. However, on occasions staff are exposed to events which transcend that which they might normally encounter. Such events should be identified and acted upon.

NHS employers must ensure timely provision of post-incident support for those learning in the NHS which may include peer group support, or a formal debriefing such as the ambulance service Trauma Risk Management programmes (TRIM) and post-trauma counselling.
(Wellbeing Guardian Principle Two)

The Workplace Wellbeing Guardian should be alert to circumstances where staff are asked to take on new or advanced roles which may expose them to new experiences where they will need support, however clinically competent they are. This can be seen for example in the case of a mental health nurse working in a crisis response team.

Where work complexity and workload changes with some roles moving to other staff, such as where general practice workload is shared with practice nurses and physician associates, the work intensity for the GP may increase.

Recommendation 20:

The Government review, *Thriving at Work* (2017), recommends that all employers, regardless of workplace type, industry or size, adopt the mental health core standards. The review, which this Commission fully endorses, believes that adopting the mental health core standards can be delivered proportionally depending on the size and type of business. The mental health core standards should provide a framework for workplace mental health and have been designed in a way that they can be tailored to suit a variety of workplaces and be implemented by even the smallest employers. Some key work on this is already being piloted by NHS Improvement.

The *Thriving at Work* review is such a vital piece of work that this Commission does not seek to replicate it herein and seeks to direct readers to it.

Key recommendations pertinent to this report include that (NHS) employers should:

1. Produce, implement and communicate a mental health at work plan
2. Develop mental health awareness among employees
3. Encourage open conversations about mental health and the support available when employees are struggling
4. Provide your employees with good working conditions
5. Promote effective people management
6. Routinely monitor employee mental health and wellbeing.

Furthermore, we believe that all providers of NHS care should deliver the enhanced standards:

1. Increase transparency and accountability through internal and external reporting
2. Demonstrate accountability
3. Improve the disclosure process
4. Ensure provision of tailored in-house mental health support and signposting to clinical help.

Performance against these standards should be routinely reported to the board of each NHS organisation and CCG board by the Workplace Wellbeing Guardian at least annually drawing on the Health and Wellbeing Framework published by NHS Employers, in response to the review, in May 2018.

The recommendations from the Government review, Thriving at Work, should be fully implemented across all NHS bodies.

Recommendation 22:

Clinical supervision is an activity that brings together skilled supervisors and practitioners (one-to-one or in a group) to reflect upon their practice. It is more prevalent in mental health nursing, midwifery and social work and less commonly implemented in medicine, general nursing and with allied health professionals including paramedics. It can support clinicians with complex situations associated with care and can provide an environment in which they can explore their own personal and emotional reactions to their work. It can allow the member of staff to reflect on and challenge their own practice in a safe and confidential environment (Care Quality Commission, 2013).[207]

All organisations should provide dedicated time for all NHS staff to periodically access a reflective learning space, such as clinical supervision. For staff that experience the emotional or psychological impact of a specific clinical incident, organisations should ensure access to debriefing and support in timely and confidential fashion. (Wellbeing Guardian Principles Two and Six)

Recommendation 21:

In previous chapters we have outlined the loss of psychologically safe and confidential spaces. The Commission consistently heard of the steady erosion of and the consistent need for spaces for NHS staff as a community to feel they can gather for rest and reflection and the opportunity to talk safely of the highs and lows of the day or night. This combined with a lack of access to simple nourishment or even the ability to take toilet breaks has left many staff feeling that their wellbeing is not valued.

All staff should have suitable, accessible, psychologically safe and confidential spaces in which to socialise, share and discuss experiences and to rest. (Wellbeing Guardian Principle Six)

Recommendation 23:

Patients have the right to formally lodge a complaint when they believe the care received has fallen short of what they have a right to expect; this is an important feedback loop and helps to identify poor practice. Complaints are taken seriously but analysis of the circumstances leading to a complaint can take time and will involve all staff and learners who were considered to be material to the circumstances surrounding the event. As such, these staff and learners are seen as being under investigation, a status that can hang over clinical staff for weeks, months or in some cases for years. The impact on a member of staff and trainees of being under investigation is far reaching and inevitably, for some has an impact upon their mental wellbeing. Many of the staff and in many cases the person complained against and caught in the vortex of an investigation will ultimately be found to have no case to answer. In many cases the complaint system was probably the wrong route when a patient simply wanted to be heard, to suggest a change in the way they have been cared for or to hear an explanation about why what happened was normal.

A national charter should be developed, working with patient groups, clinical professionals and their representative bodies, and regulators of the professions that seeks to examine the way that reflections, complaints and comments from patients and the public are handled in the NHS. This should feed into a root and branch examination of how complaint handling can be speeded up without compromising the rights of patients and staff members.

Recommendation 24:

There are occasions where NHS staff find themselves in a situation from which, if at all possible, they should be removed. An example of this is an ambulance crew that attends the death by suicide of a fellow member of the ambulance service: the crew may have to attend but should be replaced as soon as possible. Such situations are known to occur, and although we clearly do not know when they will, preparing a protocol is a proactive step. Other employers, such as Transport for London and National Rail, have protocols in place for such a contingency.

NHS service managers should develop incident protocols for when staff are placed in a situation that would disproportionately impact on their wellbeing.
(Wellbeing Guardian Principle Two)

The Commission heard harrowing accounts of the moral burden and impact of providing care, in particular as workload and work intensity is increasing. The Commission believes further research is needed into:

- The specific causes of excessive burnout, self-harm, and suicide in healthcare professionals and interventions, targeting those most at risk
- The effects of complaints on wellbeing
- A fuller understanding of the incidence of excessive burnout, self-harm, and suicide in professional sub-groups and sub-groups within these

Recommendations 25 and 26:

We have heard through the Commission's evidence sessions that tragically, staff and learners working in the NHS have died through suicide. Working in the NHS carries its own risk factors but none of these should be allowed to so impact an employee, such that suicide is seen as the only option. The NICE Guidance 105 for preventing suicide in our nation's communities are a valuable contribution to suicide awareness. The Commission feels that it has resonance for the NHS community too, working with the local multi-agency partnership for suicide prevention alongside the many other steps being recommended in this report.

Recommendation 25:

The Workforce Wellbeing Guardian in each NHS organisation must ensure that relevant elements of Nice Guidance 105, as they apply to NHS staff and learners, are implemented.

Recommendation 26:

In implementing Nice Guidance 105, the NHS should initially focus on the professional groups that are most at risk including nurses (especially female nurses). Specific mental wellbeing challenges within the paramedic workforce have been identified by the Commission, which should also be addressed as a priority.

Recommendation 27:

Death by suicide is thankfully less common in the NHS than it was but every such death is significant and more should be done to avoid them. When a person dies by a means that might be death by suicide (this may not be confirmed by the coroner for some months) there may be multiple factors, both personal and work related. Employers should consider whether there are any work related matters to be addressed to reduce the risk of further deaths. This needs to be conducted as a learning opportunity, not to apportion blame, and therefore to minimise the inhibition of learning by defensiveness.

It is recommended that a national NHS protocol is implemented in every NHS organisation to independently examine the death by suicide of any member of NHS staff or a learner working in the NHS and that the findings will be reported through the Workforce Wellbeing Guardian to the board. (Wellbeing Guardian Principle Five)

Recommendation 28:

Bereavement by suicide is a significant risk factor for subsequent death by suicide in those close to the person that initially died.

The NHS should ensure there should be clear organisational protocols for response to deaths by suicide. This should include targeted psychological support for colleagues. (Wellbeing Guardian Principle Five)

Recommendations 29 to 32:

The Commission heard that the NHS as an employer needs to reset its thinking about how we provide care and wellbeing support to our staff which is proactive and relevant to their needs while at work. We heard that immediate professional services for staff who have been impacted by what they have seen or experienced in the course of their work is often patchy and rarely immediate. We heard the current occupational healthcare service described as a 'service you are sent to' and not one that you turn to and we feel this needs to change. As an aspiration, the NHS should be considering what might be described as an 'NHS for the NHS'. We ask in this report 'who cares for the people who care for the nation?' and such an aspiration may serve to address this question. But there are other issues; we question the logic of NHS staff taking time away from their NHS workplace to access an NHS service that might be more cost and care effective if it were to be readily available to our staff through their own place of work. It is our view that the following four recommendations together begin to move the wellbeing and care support for our staff in the general direction of the aspiration described above. We see four levels of support that are set out in recommendations 19 and 30-32 (herein).

Recommendation 29:

Occupational health is a medical speciality dedicated to keeping people well at work, physically and mentally. NHS Employers recognise that 'a good quality occupational health service can help the NHS become more productive, reduce sickness absence and save money'. In many cases, occupational health input can make the difference between a NHS employee with a physical or mental health condition being absent from work on long term sick leave versus being supported to continue in their role. The benefits of this are clear for the employer, but also for the employee - significant periods of absence from work are associated with worsening of physical and mental ill health symptoms. Occupational health therefore plays a vital role in supporting wellbeing of NHS staff. However, the Commission has heard that since being classified by many trusts as a 'back office' function, occupational health has been subject to severe budget cuts (in some cases being asked to make 40% savings). The subtext of this is that the NHS as an employer appears not to value staff wellbeing at work. The Commission advocates that occupational health should be prioritised as a frontline clinical function and funded appropriately to provide proactive, responsive support to all NHS staff.

> *All employees should have ready access to a proactive occupational health service that promotes staff wellbeing. (Wellbeing Guardian Principle Four)*

Recommendation 30:

The Commission heard how organisations such as Network Rail have recognised that a traumatic rail incident could happen anywhere and at any time across their network, and that the impact upon their staff can be significant. Within their suicide prevention programme, Network Rail, in partnership with Samaritans, recognise the importance of staff wellbeing and enlisting the public's support as paramount in delivering passenger safety. The result is a comprehensive and integrated programme that has delivered specialist emotional support and suicide prevention communications materials aimed specifically at the rail industry. Turning to Samaritans they have evolved an industry-specific service, and this is something the Commission felt was needed for staff and those learning in the NHS.

A national NHS 'Samaritans-style' service should be developed with the aim of providing a complete emotional support service to NHS staff and those learning in the NHS.

Recommendation 31:

All NHS staff should have self-referral access to a practitioner psychological treatment service. Additionally, services must ensure access for those that have additional barriers to accessing local services through a nationally provided service.

Recommendation 32:

The NHS will endorse an approach which ensures rapid access referral pathways for NHS learners and employees if requested as a priority from either a GP or an occupational health clinician - 'an NHS for the NHS'

Additionally, services must ensure access for those that have additional barriers to accessing local services such as doctors in the same provider or healthcare professionals with addictions. These services should ensure safe, confidential and timely access.

Recommendation 33:

There are consistent reports of bullying and undermining across healthcare sectors internationally and the NHS is no exception, with this reported in the NHS staff survey and the GMC national training survey among other sources. This is unacceptable and is a barrier to both wellbeing and patient safety.

The work of the NHS Social Partnership Forum with NHS Employers on 'Promoting a positive culture to tackling bullying' along with the accompanying tools and resources should be adopted by all NHS service providers. *(Wellbeing Guardian Principle Six)*

For example, the *'How are you feeling? Emotional wellbeing toolkit'* provides a simple framework for genuine conversations and should be used as a simple tool for all NHS staff (both documents in *Useful Resources*).

Annex
Appendix A - The Commission

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Annex
Appendix B - Useful Resources

Business in the Community, *Reducing the risk of suicide: a toolkit for employers*
wellbeing.bitc.org.uk/sites/default/files/business_in_the_community_suicide_prevention_toolkit_0.pdf

Department of Health and Social Care, *Talk Health and Care*
dhscworkforce.crowdicity.com/category/browse/

Health Education England, *Our Work*
www.hee.nhs.uk/our-work

National Institute for Health and Care Excellence (NICE), *Preventing suicide in community and custodial settings*
(published September 2018)
www.nice.org.uk/guidance/ng105

NHS Employers
How are you feeling NHS? Toolkit (July 2015)
www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/
protecting-staff-and-preventing-ill-health/taking-a-targeted-approach/emotional-wellbeing/how-are-you-feeling-
nhs-toolkit

NHS Employers
Promoting a positive culture to tackling bullying (December 2016)
www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/tackling-bullying-in-the-nhs/
promoting-a-positive-culture-to-tackling-bullying

NHS Health and Wellbeing Framework
www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/health-
and-wellbeing-framework

Practitioner Health Programme
http://php.nhs.uk

Royal College of Nursing, *Healthy Workplace Toolkit*
www.rcn.org.uk/healthy-workplace/healthy-workplaces

Samaritans *Step by Step* service
www.samaritans.org/your-community/samaritans-education/step-step

Society of Occupational Medicine, list of occupational support services for doctors within (Sep 2018) report:
What could make a difference to the mental health of UK doctors?
www.som.org.uk/sites/som.org.uk/files/What_could_make_a_difference_to_the_mental_health_of_UK_
doctors_LTF_SOM.pdf

Universities UK, *#stepchange programme*
www.universitiesuk.ac.uk/stepchange

Universities UK (2015) *Student Mental Wellbeing in Higher Education: Good Practice Guide. London: Universities UK*
http://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2015/student-mental-wellbeing-in-he.pdf

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