

Finding and keeping

Review of recruitment and retention in
the mental health workforce

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FOREWORD

Staff are at the heart of good – and not so good – mental health services. To provide good services, we need adequate numbers of well trained and highly motivated staff. Yet there is evidence that the mental health workforce is under great pressure. There are shortages of staff in some professions and geographical areas, and signs of low morale.

Coupled with this, we have a wider picture of a strong economy and changing patterns of work and demography. This context poses challenges for the NHS and local authorities generally, and for mental health services in particular. In addition, some providers face difficult local workforce issues – for example, many have a high proportion of staff in their fifties.

Mental health services themselves have undergone major changes over the last thirty years. The old asylums have closed and there has been a significant shift into the community. However, both hospital and community services face a range of pressures in terms of case mix, settings and delivering new interventions in new structures.

The time has come to take stock, and to assess the state of the mental health workforce in terms of current and future requirements for staff. This report attempts both to do this, and to come forward with constructive solutions to real or potential difficulties in recruitment and retention. Unless these are solved it will be impossible to realise the aspiration for comprehensive services set out in the National Service Framework for mental health.

I should like to thank the review team for all their hard work, and to congratulate those services which already provide high quality support to staff and which have implemented positive human resources policies. I would strongly urge all concerned to study the analysis in the report and consider its recommendations. The costs of implementing good human resources practice are small in comparison with the possible benefits for staff and for patients.

Sir Graham Hart KCB

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The steering group for the review, which was chaired by Sir Graham Hart, is listed in Appendix 1.

In addition, the Sainsbury Centre for Mental Health would like to thank:

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In addition, two steering group members from the Sainsbury Centre for Mental Health, Andrew McCulloch and Malcolm Philip, wrote significant sections of the report.

Services visited for the review:

The Loddon NHS Trust

North Birmingham Mental Health NHS Trust

Newham Community NHS Trust

Bournewood Community & Mental Health NHS Trust

Former Lewisham & Guy's Mental Health NHS Trust

Haringey Healthcare NHS Trust

Exeter & District Community NHS Trust
Charter Nightingale Hospital
Sussex Weald & Downs NHS Trust
South West London and St George's Mental Health NHS Trust
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Sussex Weald & Downs NHS Trust
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London Borough of Tower Hamlets

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EXECUTIVE SUMMARY

This report aims to describe and analyse difficulties in recruiting and retaining mental health staff and to identify practicable and sustainable ways of addressing these difficulties.

The report presents the conclusions from a review carried out by staff from the Sainsbury Centre for Mental Health and external consultants, and is based on three main areas of work:

- desk-based research and literature reviews on stocks and flows in the mental health workforce, problems with recruitment and retention, and possible solutions;
- advice from expert consultants;
- fieldwork involving focus group discussions with professional staff and managers.

1 Recruitment and retention: the problems and pressures

Staff are at the heart of good mental health services. To provide good services, we need adequate numbers of well trained and highly motivated staff. There is extensive evidence, however, that the mental health workforce is under great pressure. There are reports of shortages of staff, but it is difficult to gain an accurate picture due to the inadequacies of the data. There is also evidence of emotional exhaustion and low morale in most staff groups.

The current position for each staff group

Psychiatrists: In 1998 14% of psychiatry consultant posts were vacant or were filled by locums. More than a third of NHS trusts recently reported difficulties with recruiting psychiatrists. The number of unfilled consultant psychiatry posts rose by 32% between 1995 and 1998.

Mental health nurses: 2.1% of nursing posts in psychiatry are considered hard to fill, and 85% of NHS trusts recently reported difficulties in recruiting and retaining nursing staff generally.

Social workers: Data on social workers working in mental health are highly fragmented and unsatisfactory. In 1997 7.9% of posts for officers in charge of homes for adults with mental health problems, and 13.2% of deputy posts, were vacant.

Clinical psychologists: The shortfall in numbers of clinical psychologists is well recognised, but is not precisely quantified. Numbers are growing steadily, but it is not clear whether this increase will be sufficient to meet policy and service demands.

Occupational therapists: In 1997 there was a 10.2% vacancy rate for full time occupational therapy (OT) posts across the NHS as a whole, and application rates to OT courses have declined by 46% in recent years.

The policy context

Workforce planning in health and social care has always been problematic. In response to recent critiques of the system, the Department of Health has issued proposals for reform in *A Health Service of all the talents* – proposals which we strongly endorse.

Positive action has also been taken in developing a human resources (HR) strategy for the NHS in *Working Together*. The National Service Framework (NSF) for Mental Health acknowledges that poor recruitment and retention is a priority. It is clear that implementation of the NSF needs more staff with more skills and competencies – such as working in a more generic and flexible way, and working in teams.

Labour market trends and the mental health workforce

There is scope for mental health services to target recruitment initiatives at several key groups, including: older people, women who are returning to the workforce after a career break, young people making training choices, and people who are changing career in mid-life.

It is also important to make mental health work more attractive to existing employees. Many NHS trusts have a high proportion of employees in their fifties who may be tempted to retire early. Some of them might like to stay on in their jobs if they could change their work role, but may be dissuaded from doing so because the NHS pension scheme is based on their final three years' salary.

Employees of all ages – whether or not they have responsibility for childcare or eldercare – are increasingly concerned about the work-life balance. Attractive employers need to provide a range of flexible working options to meet these needs.

Pressures on mental health services and staff

Understaffing and high turnover affect the quality of care for users and send services into a vicious circle. They do not have enough time, or enough staff, to improve their practice – but this makes the permanent staff they do have feel hard pressed and reluctant to stay. In response to staff shortages, some services make heavy use of agency staff and locums. These strategies for filling vacancies are expensive, destabilising to mental health teams, and make it much more difficult to ensure that a high quality and safe service is being provided.

Staff and managers working in understaffed mental health services are additionally burdened by long hours, excessive paperwork, and heavy caseloads. The risk of violence, and the grim physical environment, are further causes of discontent and low morale.

Mental health services have changed radically in recent years, but for some staff the disorientating rate of change has been accompanied by a sense of standing still in their own careers. Many staff feel that there are few opportunities not only for promotion, but for career development in a wider sense. Some staff groups have also lost role clarity and feel that their jobs are poorly paid and low in status.

The managers of mental health services are faced with a complex and daunting task, for which they are sometimes not adequately trained and prepared. They need to be able to juggle a wide range of tasks and to understand and respond to differing stakeholder perspectives. The multi-disciplinary and inter-agency nature of mental health work leaves many teams with a lack of clarity about who is in charge, who will take the blame if things go wrong, and what exactly the role of each professional group now is. There is a need not only for strong leadership of these services, but also for mental health staff to be developed as team players who are willing to be led in order to meet shared goals.

Staff attitudes and organisational performance

Many sources make clear that considerable numbers of staff in mental health services are dissatisfied with their work – but what are the more positive experiences of staff? Despite the many pressures, staff we spoke to in the course of the review gained job satisfaction from being clinically effective and seeing patients getting better, from working in teams, and from feeling that their contribution is valued.

There is good research evidence that the more satisfied employees are with their jobs, and the more committed they are to the organisation, the better the organisation is likely to perform.

2 Solutions to problems with recruitment and retention

Problems with recruitment and retention are not simply the result of staff shortages and cannot be tackled simply by increasing the numbers available for recruitment. What is the vision that is needed to transform current employment and management practice into something more attractive and supportive? What practical steps can be taken to drive the process of change?

There is much that can be done now to tackle these problems. Action can be taken at two main levels. Firstly, we propose a strategic framework to strengthen the structures of good employment and good management practice. Secondly, we have analysed the research evidence and undertaken consultation with experts to identify some targeted solutions to specific problems.

A whole systems approach to recruitment and retention

We have identified three key questions for developing a whole systems approach.

- 1 Attract and retain: how can mental health services become more attractive to potential and actual recruits?

Strategic approach: Ensure that HR strategy is at the heart of the wider organisational strategy.

The HR function provides a crucial interface between staff and their employers. This is relevant during recruitment, induction, training and development, and the agreement of pay and conditions. Good HR managers – who understand the organisation and its work – are able to offer expert advice on job design, sustaining interest and variety, and countering the effects of occupational stress and burnout. When an employee leaves, their reasons for leaving should be captured and analysed. HR management is in a good position to lobby for the changes which are essential for improved recruitment and retention – better opportunities for flexible working, improved physical working environment, and robust policies on violence against staff.

There is good evidence that HR issues have real impact on organisational performance, but HR departments still occupy a peripheral place in some mental health services. HR strategy must be built into the wider organisational strategy as a component part rather than an added extra.

There are several options for improving the HR function in mental health services. In the first instance, we see the availability of sufficient numbers of high quality and professionally qualified HR managers as an essential foundation for approaching the problems identified in this report. The important point, however, is that HR expertise should be available within mental health services, and accorded a central place within the organisational strategy. This expertise could well be developed within existing management structures, supported by HR guidance and training.

HR professionals need to be knowledgeable about the ethos of mental health services and familiar with the professional relationships and skills. If this capacity is to be developed, it is likely that a new module in HR training will need to be created.

- 2 Lead and inspire: how can mental health employers create stronger leadership, more effective management, and an organisational culture which is sufficiently robust for the whole range of mental health service settings?

Strategic approach: Promote high quality leadership and management of mental health services.

The question of who should take the lead in mental health services has always been a sticking point. What is important is to define the precise roles and responsibilities of managers and to nurture staff and managers who are capable of being led – often by someone from a different background – as well as being capable of leading.

A successful strategy to nurture leadership will need to define the required competencies for leadership of mental health services (including emotional intelligence, strategic thinking, team working, risk management and stress management), and devise selection techniques. A developmental programme to nurture a cadre of leaders will need to be devised, and services will need to create an environment that attracts and retains potential leaders.

3 Support and sustain: what can be done to support mental health staff better and to promote and protect their mental and physical health and well-being?

Strategic approach: Ensure that a mental health promotion strategy for staff is at the heart of the HR strategy.

Many of the areas which might be addressed by a mental health promotion strategy – such as increasing role clarity, reducing paperwork, managing stress and improving job design – overlap with areas to be addressed by strengthening leadership and developing the HR management function. Similarly, some of the ways in which HR managers can work to reduce pressure on staff are also part of a mental health promotion strategy. A successful strategy for tackling recruitment and retention problems will require the close bonding of these three mutually interdependent strategic approaches.

Practical approaches to particular problems and issues

Within the context provided by the strategic framework, there are many helpful tactics for approaching specific problems, and these have the potential to be highly effective in driving immediate improvements. For ease of reference, we have organised this material as An A-Z of interventions to improve recruitment and retention (not summarised here – see page 76).

Developing a local strategy to improve recruitment and retention

Local strategies to tackle recruitment and retention can build on the findings of this review, but should be geared to local needs. This can be achieved through the steps set out below.

- 1 Are there current or likely future shortages? Gather local information on vacancies and turnover, and on the state of the labour market.
- 2 Solutions to the problem: analyse the local situation in relation to issues raised in this report.
- 3 Implementation of the solutions: develop a local strategy which is focused on the identified problems.
- 4 Evaluation of the strategy.

Core conclusions

1 There are shortages of appropriately skilled staff

There are current and potential difficulties in the supply of staff in terms of both quantity (the numbers of staff available) and quality (the skills and competencies of staff).

2 Practical steps can be taken

There are practical and evidence-based steps which can be taken to tackle recruitment and retention difficulties. The Government has provided a helpful policy and financial context. Much can also be done to unlock energy and commitment from existing staff.

3 A whole systems approach is needed

Problems with recruitment and retention need to be tackled within a whole systems approach which has the overall aim of strengthening the structures of good employment and good management practice. The strategy as a whole will only be as strong as its weakest link. We have identified three strategic priorities:

- Attract and retain: Ensure that HR strategy is at the heart of the wider organisational strategy.
- Lead and inspire: Promote high quality leadership and management of mental health services.
- Support and sustain: Develop and implement a mental health promotion strategy for staff.

Recommendations

- 1 Employers need to set up adequate management information systems.
- 2 The Department of Health needs to harvest the information collected under Recommendation 1 to inform national planning and policy development.
- 3 Employers who decide that they have significant problems in relation to recruitment and retention need to develop clear local strategies and action plans.
- 4 This review strongly supports the proposals on workforce planning contained in the Department of Health consultation document *A Health Service of all the talents*.
- 5 Employers should consider what steps should be taken to make full use of the mature workforce (i.e. those aged 50-70).
- 6 The Department of Health should review the current pensions arrangements to determine what impact they have on the retention of mature staff.
- 7 All major employers in the sector require sufficient numbers of professionally qualified HR staff.
- 8 Adequate time must be set aside for Continuing Professional Development for all clinical staff.

- 9 Personal Development Plans and Training Strategies should address management and leadership development where this is appropriate for individual staff or staff groups.
- 10 Managers and clinical supervisors of professional staff should actively manage workloads to maximise the amount of patient contact.
- 11 Each employer should appoint a lead director / deputy director to take responsibility for the simplification and integration of procedures such as care planning and record keeping.
- 12 Each employer should develop a mental health promotion strategy for its workforce. Strategies should be evaluated and reviewed annually.

INTRODUCTION

THE REVIEW: ISSUES AND METHODOLOGY

1 The need for a review of recruitment and retention in the mental health workforce

The quality and quantity of staff are fundamental to establishing and sustaining modern and comprehensive mental health services. Difficulties in recruiting and retaining mental health staff have been a serious cause for concern, both locally and centrally, for several years. This has applied particularly to inner city services. Many NHS trusts and social services departments are carrying significant numbers of vacancies, and some make continued heavy use of agency and locum staff.

The continuity of care and the sustainability of services are further threatened by worrying levels of sickness absence, low morale and burnout among both hospital and community staff.^{1,2,3,4} Widespread psychological distress among both managers and direct care staff has significant implications not only for recruitment and retention, but also for the capacity of the mental health workforce to deliver improved outcomes. A coherent approach to the organisational factors which undermine emotional well-being is an essential part of any strategy to improve the quality and quantity of the mental health workforce.⁵

If problems with recruitment and retention are not addressed, there is a danger that large sections of existing mental health services will not be sustainable. We also run the risk that the National Service Framework (NSF) for mental health, launched last year, will not be deliverable.⁶ The NSF has significant workforce implications. Its aspirations cannot be delivered without a combination of increased numbers of staff and the rapid enhancement of skills and competencies. The latter include teamworking, partnership working, and working in more generic and flexible ways.

The NSF identifies improved workforce planning as one of several national programmes to underpin implementation, and sets action points for tackling problems with recruitment and retention. The broad sweep of policy on health and social care also offers numerous pointers and many helpful initiatives to strengthen human resources (HR) practice.

What is needed, however, is a whole systems approach to recruitment and retention problems that takes detailed account of the many and complex factors which make mental health services distinctive. In this review, and in Part I of this report, we have brought together:

- information on the current position of the mental health workforce;
- analysis of the relevant policy initiatives;
- an overview of labour market trends;
- and a scrutiny of the pressures which problems with recruitment and retention place on mental health services and the people who work in them.

In Part II of the report we suggest that there is much that can be done now to take action and drive improvements. We identify an overarching approach, backed up by a modest number of recommendations. We also provide building blocks for thinking through detailed local solutions to particular problems and issues.

2 The scope of the review

Some understanding of the contributory factors which cause difficulties in the supply of staff has been built up over recent years. However, the breadth and depth of work done so far is limited. The purpose of this review was to bring together in one place an overview of both the problems and the possible solutions.

The review therefore had the following terms of reference:

- (i) to examine the current and future supply of mental health staff, and identify the factors affecting their recruitment and retention;
- (ii) to assess the need for action to address the identified difficulties;
- (iii) to make recommendations on the specific steps required to secure an adequate supply of mental health staff to meet future needs.

In addressing these terms of reference we encountered some significant gaps in information. For example, there is very little hard information about stocks and flows in some staff groups. We have drawn together the best available information about the current and future supply of mental health staff. However, we have looked at this information in the context of strategies for improving recruitment and retention, rather than attempting to construct a workforce planning model. We welcome the recent publication of new proposals to reform workforce planning – *A Health Service of all the talents*.⁷ The approach suggested in this consultation document has the potential to secure significant and lasting improvements.

In preparing the report of the review we have aimed to produce a document that will be as helpful as possible for practitioners and managers in the field while also making a distinct contribution to the existing policy and guidance. To fulfil this aim, we have focused on strategies and tactics for achieving immediate and medium term solutions to problems with recruitment and retention. We have brought together in one place an analysis of the problems and expert advice on the possible

solutions, and, crucially, we have gone out and listened to what staff themselves have to say about these issues.

The review team has not assumed that numbers of staff alone will improve outcomes. Rather, we have considered how to deliver a workforce with the right skill mix, morale, and level of productivity to deliver the required patient outcomes. It might well be that a smaller workforce – with enhanced skills and stronger leadership – could deliver more than a large, demotivated and poorly trained one.

In order to fulfil the terms of reference the review examined the following types of evidence and analysis:

- that relating to recruitment and retention in the different professional groups;
- existing solutions to recruitment and retention problems, as completely novel solutions are unlikely to be forthcoming or effective. These include management action to make better use of existing staff.

The review covers:

- adult mental health services in England, although it will be of wider relevance across the UK and across all mental health and related services;
- all trained and untrained staff, but not volunteers;
- practitioners' own perceptions of the current problems and their possible solutions, including views collected from front-line staff.

The review did not aim to cover:

- pay, *per se*; although it touches upon evidence and views about pay as part of the total employment package;
- training, *per se*; but again, the availability of developmental opportunities for staff appears to be highly relevant;
- staff not employed to work specifically with people with mental health problems, such as primary care staff.

3 The methodology of the review

The steering group for the review is listed in Appendix 1. The group was chaired by Sir Graham Hart, Chair of the King's Fund and former Permanent Secretary at the Department of Health. The steering group consisted of a distinguished group of professionals and HR experts. Its role was to advise on the development and work of the review. However, the Sainsbury Centre for Mental Health was responsible for the detailed preparation and for the contents of this report. The group met six times during the period of the review, which ran from February 1999 to May 2000.

The main planks of work underpinning the review were as follows:

- a call for evidence;
- in-house analytic work and literature reviews;
- advice from expert consultants;
- analytic work commissioned from the Institute for Employment Studies;⁸
- fieldwork involving focus group discussions with professional staff and managers.

Unless otherwise stated, all data refer to adult mental health services in England.

The call for evidence

This is reproduced in Appendix 2 and appeared in the *Health Service Journal* and *Community Care* on 17.2.99. The list of organisations that responded forms Appendix 3. The views, opinions and information put forward by the bodies that responded have formed an important foundation for the report.

Focus group discussions

In order to gain the views of front-line staff working in mental health services, group discussions and individual interviews were held in nine NHS trusts, three social services departments and one independent health care provider. All the sites visited are in England, distributed across urban (including inner city), metropolitan and rural areas. All discussions except one were uni-professional, and discussions were held separately with those in management and non-management positions. The purpose of each discussion was to identify local and national incentives and disincentives that staff thought affected recruitment and retention and to discuss what needs to be done to address these difficulties.

About this report

This report is aimed at all those who have an interest in sustaining and developing the mental health workforce, including chief executives of NHS trusts, directors of social services, HR directors, senior managers and clinicians, relevant national agencies and professional bodies.

A separate Executive Briefing summarising the main messages of this report is also available from the Sainsbury Centre for Mental Health.

PART I

RECRUITMENT

AND

RETENTION

THE

PROBLEMS

AND

PRESSURES

Introduction

This chapter summarises data on what is known about vacancies, turnover, and growth in each of the main staff groups within mental health services: psychiatrists, mental health nurses, social workers, clinical psychologists, and occupational therapists (OTs). We also refer here to evidence of low morale and psychological distress.

More detailed information and tables are set out in Appendix 4.

Key points

- Data on the current position for each staff group are of variable quality.
- There are staff shortages in all the main groups in terms of current and anticipated demand.
- There is widespread evidence of low morale and psychological distress within the mental health workforce.

1 Inadequacies of data relating to the mental health workforce

Data relating to the mental health workforce are not comprehensive. For some staff groups it is relatively straightforward to achieve a headcount and to predict the number of staff who will become available over the next few years. Generally, however, there are poor data on movements into and out of the workforce – for example, resignations. This makes it difficult to build up an accurate picture of the nature and extent of problems.

There are some other important problems with the data. Firstly, the available data often span a range of inconsistent time frames, making comparisons difficult even within occupations. The consequence of this is that virtually no meaningful series of time-data exist, making trend analysis and forecasting difficult or unreliable.

Another area of difficulty is that, for some staff groups – such as social workers and OTs – the categorisations used make it difficult to separate those who work in mental health from those working with other client groups.

In addition, it is rare to find a group where breakdowns by age, gender, employment status and ethnicity are available.

2 Psychiatrists

The best evidence is available for psychiatry. The pressures are considerable, with very heavy use of locums, which is often highly unsatisfactory from a clinical and management point of view. In 1998 14% of consultant psychiatry posts were vacant or were filled by locums.⁹ There was a 32% increase in unfilled consultant posts between 1995 and 1998. In 1999, 36% of NHS trusts employing psychiatrists reported recruitment difficulties and 5% reported retention difficulties – both these were the highest levels for any specialty.¹⁰ Some inner city trusts experience particularly severe difficulties.

Numbers of psychiatrists are low relative to perceived demand. The Government has recently announced an increase in the training places available in psychiatry with the intention of providing an extra 1,500 mental health specialists by 2006/7.¹¹ Numbers of psychiatrists have been rising gradually for some years, but growth is currently insufficient to meet demand given vacancy levels and the requirements of recent policy initiatives. There is a greater tendency for expansion in subspecialties other than rehabilitation, psychotherapy and general adult psychiatry which are the mainstay of services.

In addition, there is evidence that morale amongst psychiatrists is low. They feel overworked and emotionally over-extended, and some experience difficulties in finding the time or motivation for multi-disciplinary working.^{12,13} Changes in the roles of all community staff have raised questions about who has responsibility for clinical and managerial leadership.

17% of consultant psychiatrists who retired early in 1995 and 1996 cited workload as the main reason. 70% cited increasing bureaucracy and paperwork, 51% staff shortages and 37% local bed closures as contributory reasons.¹⁴

3 Mental health nurses

While the problems in recruiting mental health nurses are widely publicised, hard data on the extent of vacancies are limited. A Department of Health survey in 1999 indicated that 2.1% of all nursing posts in psychiatry were considered hard to fill.¹⁵ 85% of 100 trusts surveyed by the NHS Executive reported difficulties both in recruiting and retaining nursing staff generally, commonly in D and E grades and particularly in mental health.¹⁶ The site visits for this review confirmed that NHS trusts are having difficulties with nursing vacancies and some are making heavy use of agency nurses.

The most recent (unpublished) Department of Health figures for the number of mental health nurses is 35,207 whole time equivalent (wte). In 1998 nearly a quarter of mental health nurses (working in child and elderly services as well as adult services) were aged 45-54.¹⁷

The Department of Health's most recent (unpublished) projections for future numbers of mental health nurses are reasonably optimistic, and show a growth of qualified nurses in the medium term.

Low morale has repeatedly been identified as a priority issue facing mental health nurses.¹⁸ Recent reviews have indicated that the transfer to community-based services has contributed to this situation.^{19,20} There are uncertainties about the roles of the different staff groups within community mental health teams (CMHTs), and anxieties about adapting to new philosophies of care and types of intervention.

High psychological disturbance, work overload, lack of support, and ill health associated with poor management style, have been found amongst both hospital and community mental health staff.^{21,22}

4 Social workers

There is little information on the supply of social workers in the mental health workforce. The "best" available data suggest that about 4,500 social workers were working in adult mental health in 1996 but these data lack credibility.²³ Turnover rates for staff working in residential homes in the mental health sector – whether social workers or not – are high (16.8% *per annum* for officers in charge).²⁴

A 1995 survey found that 54% of social workers in CMHTs were emotionally exhausted.²⁵ Bureaucracy and paperwork are a major source of dissatisfaction.²⁶

5 Clinical psychologists

The shortfall in numbers of clinical psychologists is well recognised but is not precisely quantified.^{27,28} The total stocks of clinical psychologists can be estimated from reliable sources, but there is no breakdown of the numbers working in adult mental health. An unpublished Department of Health figure for the current total stock is 3,706 (wte). Department of Health projections (unpublished) show steady but modest growth in the numbers of clinical psychologists, but it is not possible to say whether this rate of increase is sufficient to meet current or future demand.

As for other groups, there is evidence of emotional exhaustion and role confusion.²⁹

6 Occupational therapists

Occupational therapy is the only discipline apart from psychiatry where there are good data on national vacancy rates. Occupational therapists (OTs) work in a variety of sectors, but the overall picture is relevant to mental health, where approximately 30% of all OTs work.

In 1998 there were between 3,851 and 4,280 OTs working in mental health.³⁰ Vacancy rates and turnover rates have been high: a 1997 survey showed a 10.2% vacancy rate for full-time OTs and a 15.1% turnover rate.³¹ However, recent data from the Department of Health suggest an average three month vacancy level of only 1.9%.³² This figure must be questioned on the other evidence available to this review.

Application rates to OT courses have declined by about 46% over the last five years. The current ratio of male applicants to female is 1:11.³³ Whilst it is predicted that the supply will increase gradually, there are concerns that 40% of OTs working in mental health have done so for two years or less, and that there is a shortage of more experienced staff.³⁴

OTs, like others, seem to be experiencing low morale and role confusion.³⁵

7 Support workers

Few hard data are available about the supply of support workers, who are present in about 40% of CMHTs. There is evidence, however, that they experience burnout and variable levels of job satisfaction.³⁶ There are no data about the supply of support workers, but this must relate to the state of the labour market as a whole.

Conclusions

Mental health services face severe pressures in terms of staff shortages, high turnover, and low morale across all the main staff groups. The precise extent of these problems has been difficult to establish due to the lack of comprehensive and standardised data.

In Chapter 2, we look at the policy context and assess how helpful current policy is likely to be in addressing some of these problems. There have been major recent developments in policy on workforce planning and HR management. These should help to correct current information deficits, and to support good management practice.

Psychological distress among NHS staff

An independent review concluded that levels of psychological disturbance among all groups of NHS staff were worrying.³⁷ A study of over 11,000 employees from 19 NHS trusts found that 26.8% of the health service workers reported significant levels of minor psychiatric disorder, compared with 17.8% of people in the general population.³⁸ Psychiatric morbidity was higher among managers, doctors, nurses, and professions allied to medicine, and lower among administrative and ancillary staff. Female doctors and managers showed a much higher prevalence of minor psychiatric disorder than their male colleagues.

There is some evidence that NHS managers are under more strain than non-NHS managers, with between one third and one half of them experiencing high levels of psychological disturbance.³⁹

Levels of burnout experienced by mental health staff

Burnout is a syndrome of feeling emotionally over-extended and exhausted, with decreased feelings of competence and achievement, and impersonal responses to service users. It is seen as a possible product of long-term “helping work”.

Burnout scores among all members of 302 CMHTs surveyed in 1994 indicated that they were emotionally over-extended and exhausted.⁴⁰ They did not, however, seem to be experiencing detachment from service users, or feelings of reduced competence and achievement. Emotional exhaustion was highest among consultant psychiatrists, and they also reported the greatest sense of depersonalisation.

More recently, a 1997 study found similar levels of burnout among six community teams from different socio-demographic areas in Britain.⁴¹ Community care staff experienced high levels of burnout – higher than those found in any published study of hospital-based workers. Working in an inner city seemed to be associated with higher levels of burnout. A study of 160 mental health care workers in inner London also found that community workers experienced more psychological distress and emotional exhaustion than hospital-based staff.⁴²

Results from the largest study of burnout in mental health care workers to date, the Claybury Stress Study,⁴³ found high levels of emotional exhaustion in both community-based and ward-based nurses. Depersonalisation and personal accomplishment scores were worse for ward-based nurses than for their community-based colleagues. Their sense of achievement and their ways of relating to service users were adversely affected.

Introduction

Workforce planning in health and social care has always been difficult. In response to the recent critique of the system by the House of Commons Select Committee on Health, the Government has produced proposals for reforming workforce planning – *A Health Service of all the talents* (2000).⁴⁴

Positive action has also been taken in developing an HR strategy for the NHS – *Working Together* (1998).⁴⁵

The National Service Framework (NSF) for Mental Health⁴⁶ acknowledges that poor recruitment and retention of the mental health workforce is a priority area, and that workforce planning needs to be strengthened and supported. Indeed, the NSF cannot be carried forward without more staff across all the professions.

In the wider policy context, there are several strands of policy which should help to facilitate the entry, or return, to the workforce of certain key groups – such as older people, women who have had career breaks, young people who are entering training, and people who undertake retraining in mid-career.

Finally, there are several important elements of employment policy which have come from Europe in recent years – covering, for instance, working hours and the rights of part-time workers.

Key points

- Recent policy initiatives have addressed problems with workforce planning and sought to develop an HR strategy for the NHS.
- Mental health policy has been carried forward by the NSF, which has major staffing implications across the mental health workforce.
- National policy needs to be turned into deliverable and sustainable plans for each mental health service.

1 Policy on workforce planning in the NHS

Workforce planning in the NHS has been notoriously problematic, partly because it has been carried out by a whole range of bodies working independently.

- The Advisory Group in Medical and Dental Education, Training and Staffing (AGMETS) provides national advice on the process as a whole.
- The Specialty Workforce Advisory Group advises on the numbers of Specialist Registrar posts needed to meet future consultant requirements; it is a subcommittee of AGMETS.
- The Medical Workforce Standing Advisory Committee determines the numbers of students who should be admitted to medical and dental schools.
- The Medical Practices Committee determines the distribution of GP practices.
- The Local Medical Workforce Advisory Groups advise on medical workforce issues locally.

Workforce planning for non-medical groups is employer-led through education consortia which bring together representatives of health authorities, NHS trusts, GPs, social services and the independent sector to estimate their workforce planning needs and to plan the necessary education and training. The work of consortia is gathered by Regional Education and Development Groups which advise the NHS Executive Regional Offices on workforce planning and education. A sub-group of the NHS Executive provides the national overview, advises on education and workforce issues and makes recommendations for change.

With the reduction in the role of NHS Regional Offices in the early 1990s, regional manpower planning sections were closed and some important technical skills were lost to the NHS. Planning for the future has been done by looking at the past, or at present shortages, rather than making forward projections. This is compounded by serious weaknesses, both locally and nationally, in the information gathered for workforce planning. For example, there are no national comprehensive data on the mental health workforce in England.

Workforce calculations are further complicated by the long training periods required and the move of training into higher education, which makes it more removed from the service. Drop-out rates and patterns of retirement make calculations even more difficult.

Some of these problems were acknowledged by the Government in evidence presented to the House of Commons Select Committee on Health in 1999:

“Successive governments have tried to achieve better planning of the workforce ... Workforce planning is not an exact science, and is subject to complex variables ... There are information gaps ... The timescales are challenging ... Approaches to healthcare are changing and it is difficult to forecast with accuracy the long-term implications of skill mix and productivity changes, shifts in clinical care, technological advances or changes in patterns of disease.”⁴⁷

House of Commons Select Committee recommendations 1999

The Select Committee made recommendations for radical changes to the current system.⁴⁸ It recommended that an integrated planning body should be developed and that the medical and non-medical planning bodies should work together more closely. Any new system should not only incorporate the national overview provided by the sub-group of the NHS Executive, but also actively promote a national strategy for workforce planning.

The way forward for workforce planning: *A Health Service of all the talents*

The Government has accepted the recommendations of the Select Committee and proposals to reform workforce planning were published in April 2000: *A Health Service of all the talents*. This document identifies the need for new systems to address the following tasks:

- streamlining workforce planning and development;
- maximising the contribution of all staff to patient care;
- modernising education and training;
- developing more flexible careers and addressing specific perverse incentives arising from the NHS pension for older staff;
- expanding the workforce.

Workforce planning must be driven by service requirements rather than historical factors. Understanding the requirements of the service should allow more analysis of the skills, competencies, numbers and types of staff required to meet these needs. This should allow the education and training agenda to be more fully co-ordinated with workforce planning. Some of the more specific proposals are set out below.

- Workforce planning should be aligned to service planning at local level through Health Improvement Programmes.
- Workforce plans should be developed on a multi-disciplinary basis, focusing on the services to be delivered, and looking across primary, secondary and tertiary care.
- A National Workforce Development Board, supported by Care Group Workforce Development Boards, should be responsible for ensuring the proper integration of workforce issues with service development. This will need to take account of skill-mix changes, and research and development findings. It should incorporate the work of existing uni-professional groups.
- The merger of education and training levies will provide an integrated funding stream.
- Central action will be required to co-ordinate work on skill-mix changes, and the development of new types of healthcare worker.
- Planning systems should take account of the transformations taking place in the NHS workforce, including the need for more teamworking, and working in more flexible ways.

The proposals in *A Health Service of all the talents* have the potential to deal with many of the problems of workforce planning identified both for the health service environment generally, and for mental health services in particular. For the first time a single stream of activity has been identified, working from population need, through service configuration, to skills and numbers of staff, and the requirements for education and training.

Other key issues which must be dealt with in the new strategy will include:

- the development of an adequate cohort of people skilled in workforce planning;
- integration of workforce planning at least across health, social care and the independent sector;
- establishment of adequate data streams of good enough quality for forward looking analytic work;
- securing the support of key stakeholders, including professional bodies;
- links to the training agenda – for example, addressing the need to train staff in team working.

If these building blocks can be put in place, there is every chance of developing a much better system of workforce planning.

2 HR policy in health and social care

Recent Government policy in relation to the NHS and social care has placed significant emphasis on HR issues. The 1998 document *Working Together* sets out an HR strategy for the NHS.⁴⁹ There is no equivalent HR strategy for social care, but the White Paper *Modernising Social Services* describes an important training and quality agenda for the social care workforce.⁵⁰

Working Together

Working Together sets out three strategic aims:

- 1 to ensure that there is a quality workforce fit to deliver health and social care objectives;
- 2 to improve the quality of working life for staff;
- 3 to address the management capacity to deliver the HR agenda.

These priorities are helpful in tackling problems with recruitment and retention of the mental health workforce. As we discuss in Chapter 4 of the report, there are many aspects of working life in mental health services that are not satisfactory for many staff. Some services lack the strong leadership and management to carry forward the necessary changes. Equally, there are concerns about the quality, skills and skill-mix of the workforce.

Within the strategy, specific targets for improving recruitment and retention are identified. By April 2000, each local employer was supposed to:

- have in place an annual workforce plan;

- demonstrate year on year improvement in retention rates for all health professional staff;
- demonstrate progress towards a workforce that year on year becomes more representative of the community it serves at all levels of the organisation.

In addition, some of the objectives relating to staff involvement, creating a healthy workplace, and other aspects of good HR practice, have great relevance to recruitment and retention. Crucially, *Working Together* gives prominence to the link between good management, good staff morale, and good outcomes for patients:

“There is now evidence from the NHS itself which shows that:

- *poor staff management contributes to factors which damage the delicate infrastructure and networks that deliver patient care – and in turn exacerbates staff turnover, low morale and workbased stress and exhaustion;*
- *organisations which are practising progressive HR practices are more productive and efficient.”*

The objectives set out in *Working Together* have been supported by further guidance and policy developments, including documents on improving working lives and improving the health of the workforce.^{51,52,53,54} In addition, a training strategy is being developed by the National Training Organisation, Healthwork UK.

Modernising Social Services

This White Paper does not attempt to create a comprehensive national HR plan for social care, but it provides some tools for doing so through the creation of a General Social Care Council, and developing a national training strategy. The national training strategy will be led by the new Training Organisation for Personal Social Services. In mental health, however, it is Healthwork UK which has the overall lead for developing the training agenda.

Strengths and weaknesses of HR policy in health and social care

It is welcome that there is now a national HR strategy for the NHS and a clear leadership role within social care. Much of the policy reflects known good HR practice, including good management generally. For the first time we have a clear lead from the centre and a clear framework for tackling these issues. This will make the work of those who need to address HR issues in mental health services significantly easier, and represents an opportunity which should be seized.

NHS trusts and other agencies must now give high priority to this framework, and thus to developing the HR management capacity to deliver on ambitious targets. This will not necessarily be easy but the increased level of resources currently available for the NHS will help.

However, some of the national targets are unachievable for some NHS trusts, because outcomes are largely determined by externally driven factors such as the economy and the health labour

market within the relevant travel-to-work area. There is a danger that vague or unachievable targets will demotivate local services.

In social care there is an emphasis on national organisations, including national training organisations, developing the capacity and leadership to drive and support change. This poses some risks, given that the lines of accountability are inevitably weak. Greater account needs to be taken of the increasing blurring of boundaries between health and social care particularly in relation to the different health and social care cultures. This labour market will need to be treated increasingly as a single market.

Recent Government action on HR issues in health and social care

The Government has backed up the recent emphasis on HR issues by:

- increasing the supply of doctors, with a target of providing 1,500 more mental health specialists by 2006/7;
- setting new targets to tackle workforce discrimination for senior jobs in the NHS;
- building a strategy to develop the nursing role and nursing leadership. As part of this there are plans to:
 - train 10,000 extra nurses to prescribe over three years;
 - set up a leadership programme;
 - increase budgetary control for senior nurses;
 - appoint a Nurse Housing Co-ordinator to get more affordable homes for nurses;
 - double the number of nurse consultants.

Other measures can be expected as part of the National Plan for the NHS, particularly within the theme focusing on professionals. It will be important for mental health services to take full advantage of such initiatives.

3 Mental health policy

One of the priorities for mental health policy is to support the development of the mental health workforce and tackle some of the problems with recruitment and retention. The issues are complicated, but it is also fair to say that the rapid rate of change in recent mental health policy is, in itself, a factor which has contributed to poor recruitment and retention, and to the negative image of mental health care.

As we discuss in Chapter 4 of this report, many staff in mental health services feel dispossessed of familiar professional roles and ways of working because of some of the major policy and organisational changes in recent years. The mental health workforce needs to move towards more flexible and generic ways of working. Mental health services, at the same time, need to promote

more flexible employment practice to secure and retain good staff. Both types of flexibility need to be underpinned by a stable policy environment. There needs to be more time for changes to be understood and evaluated, and for the workforce to be able to adapt.

The National Service Framework for Mental Health

The National Service Framework (NSF) for Mental Health (1999) sets national standards and defines service models for mental health services. As the main plank of current mental health policy, it is clearly of central relevance to this review. More specifically, we need to keep several linked aspects of the NSF in view:

- more staff will be needed;
- these new staff, and current staff, will need some different skills and competencies in different combinations;
- they will need to be supported by strong leadership and attracted by better working conditions and enhanced incentives such as professional development;
- they should form a more representative cross-section of the communities they serve;
- by prioritising mental health promotion as one of the national standards, the NSF offers the opportunity for mental health services to set their own houses in order: implementation of the NSF must safeguard the mental health and well-being of the mental health workforce.

The NSF identifies several action points in relation to recruitment and retention:

- 1 making mental health a priority within wider work on recruitment and retention, including attracting people from black and ethnic minorities;
- 2 ensuring implementation of flexible and family friendly working;
- 3 tackling discrimination and harassment and reducing workplace accidents and violence;
- 4 identifying priorities for stress management and implementing mentoring and supervision.

These individual items need to inform the local development of coherent action plans for tackling the recruitment and retention issue. The Department of Health has set up a Workforce Action Team to take forward this agenda nationally.

In response to the NSF, the *National Priorities Guidance 2000/1 – 2002/3* has set three specific targets for mental health services which have clear staffing implications:

- 100 more 24 hour nursed beds are planned by March 2001 in addition to the 316 currently in development;
- 123 assertive outreach teams are planned now from a base of 60 at the end of 1998/9 – with 170 required by March 2001;
- 471 extra secure places are being developed.^{55,56}

The implications of the NSF for workforce planning

While the overall impact of the NSF is hard to quantify in exact terms, it seems likely to lead to an increased demand for all groups of staff covered by the review. In practice, much depends on the targeting of new resources over and above baseline allocations.

Standard one: Mental health promotion

Delivery of standard one will require greater knowledge of mental health promotion, and greater public health expertise in relation to the determinants of mental health. Standard one will also involve a much greater degree of working across professional and sectoral boundaries than other standards, notably in relation to the many agencies concerned with the social exclusion agenda.

Standard one also has training implications for primary care teams, who usually do not have mental health promotion included in their training. Primary care teams are not currently in a position to take the lead role in either mental health promotion, or managing minor mental distress. In terms of existing skills and expertise within the NHS, and the need for multi-agency working and managing broad based alliances, standard one is probably the most challenging standard to deliver.

Standards two and three: Primary care and access to services

Standard two has implications for the training of primary care staff and for the numbers of secondary care staff required to work in primary care settings.

Standard three has major staffing implications. 24 hour access will require sufficient staff to roster at least some teams around the clock. This might require an increase in the staffing of CMHTs of between 10 and 30% – equivalent, for example, to at least 1,000 community mental health nurses nationally. There are also more limited implications for manning help-lines with well trained staff.

Standards four and five: Effective services for people with severe mental illness

These may require significant increases in community staff to provide adequate services through assertive outreach and community teams. More staff may also be needed for increased numbers of supported accommodation places. Some areas will also need to staff increased numbers of hospital beds. The main demand will be for nurses and psychiatrists, but all professions will be affected.

Standard six: Caring about carers

If fully implemented, this standard would require significant staff increases, especially in the numbers of social workers. If each of the 50,000 most hard pressed carers were allocated a social worker with a caseload of 30, 1,667 new social workers would be needed.

Standard seven: Preventing suicide

This has limited workforce implications, but the leadership capacity and knowledge of mental health promotion will need to increase across health authorities and providers.

The *National Priorities Guidance* also emphasises the development of 24 hour access, which as stated above has major staffing implications. Child and adolescent services are also a priority, and this will increase demand within the sector as a whole.

4 Wider policies supporting entry or return to the workforce

There is a wide range of policies which can help to support strategies to improve recruitment and retention in the mental health workforce. The main strands of importance are set out below.

Help for individuals to retrain and acquire skills

As part of the theme of lifelong learning, the Government is pushing forward a number of initiatives including:

- employment zones, which will provide a range of support for long-term unemployed people;
- the creation of a new unit to tackle fundamental skills deficits such as illiteracy;
- extension of the New Deal, including, for example, a job grant for starters and help for lone parents;
- the establishment of a variety of mechanisms, including, for example, the Regional Development Agencies' Skills Development Fund and the Connexions Service, to encourage young people over 16 into education and training;
- the creation of a National Skills Task Force.

Support for family friendly policies

Recent action includes:

- the creation of extra childcare places;
- implementation of the Parental Leave Directive;
- implementation of the Working Families Tax Credit and the Childcare Tax Credit.

Support for equal opportunities

This issue is being carried forwards through:

- an Age Diversity campaign aimed at encouraging employers to use both older and younger employees where appropriate;
- work to publicise the business benefits of achieving a representative workforce.

Support for women in achieving greater equality in the workplace

Support in this area includes:

- action to deliver equal pay;
- support for women retrainers under Welfare to Work.

Such initiatives may have a significant impact on recruitment and retention in the mental health workforce. Providers can build on these initiatives and on information about local workforce profiles. In expanding and developing the mental health workforce, it may be worth using existing national initiatives to target:

- older people;
- women returners;
- younger people;
- retrainers.

5 European initiatives in employment practice

The European Union (EU) is carrying forward a major work programme on employment, much of which is of relevance to this report. Key elements in the EU work programme which have a strong impact on the mental health workforce include:

- the 1993 working time directive, which placed a ceiling on the maximum average number of hours an employer can require employees to work;
- the four directives adopted under the Agreement on Social Policy, covering: works councils; parental leave; an EU level framework agreement between employers and Trade Unions on part-time work; and on the burden of proof in sex discrimination cases;
- the requirement to create National Action Plans for employment covering employability, entrepreneurship, adaptability and equal opportunities.

The forward work programme also contains items of key relevance:

- EU Employment Guidelines which address, *inter alia*, the shift from welfare to work principle, and the need to tackle the challenge of the ageing labour market;
- the EU Social Action Programme 1998-2000 which aims to carry forward initiatives on issues including skills, mobility and social exclusion.

Conclusions

We have looked at some of these policy initiatives in detail. Broadly speaking, the policy context is helpful, and useful programmes and guidance have been produced in support. However, local agencies need to be able to build on all this policy and guidance in order to produce realistic and sustainable plans that are tailored to their own circumstances. In order to do this they will need to develop an overarching framework for scrutinising local problems with recruitment and retention. The rest of this report seeks to support this process and to identify action which can be taken to deliver real improvements.

Introduction

In Chapter 2 we looked at the policy context for health and social care generally, and at the broader sweep of relevant policy. There is scope for targeting recruitment and training initiatives at some of the following groups: older people; women returning to the workforce after a career break; young people entering training; people who are considering retraining in mid-career.

In this chapter, we look at these groups in relation to current demographic and labour market trends,⁵⁷ and assess their particular needs. What are the incentives for older people to stay in mental health work, for women to return to it, for younger people to train in it, and for others to change to a mental health career in mid-life? Even from this brief list, numerous pressures and considerations arise – pensions, eldercare, childcare, flexible working, accommodation, and financial support during training.

Key points

- The population and the labour force are ageing; eldercare is a significant issue.
- The current early retirement culture in the public sector may mean that increasing the flow of young people into training will not fill the gaps left by people leaving the workforce early.
- There continue to be increasing numbers of women in the workforce, with more needs for flexible working and family friendly policies.
- There are more graduates in the workforce, with greater expectations than the school leavers who used to go straight into work, but not necessarily with the right skills for employers.
- Traditional industrial jobs have declined and the service sector has grown.

1 The match between jobs, people, and skills

There are staff shortages and problems with recruitment and retention across health and social care. The Department of Health has acknowledged shortages in various staff groups, including psychiatric nurses, occupational therapists, and psychiatrists.⁵⁸ In Chapter 1 (and Appendix 4),

we set out the most convincing recent data on the shortages in the mental health workforce. More than a third of NHS trusts recently reported difficulties in recruiting consultant psychiatrists – this was the highest level of difficulty for any specialty. Similarly, half of the trusts examined had trouble recruiting psychiatric nurses – this was the second highest level of difficulty across the specialties.⁵⁹ Another study found that during night shifts one psychiatric ward in three in London was staffed solely by bank and agency staff.⁶⁰

Topping up the numbers of staff available for recruitment will be a major achievement – but the current difficulties are not simply a matter of numbers. We need to ensure that we have the right staff with the right skills in the best possible combination. In other words, we need to improve the match between jobs, people and skills.

2 Incentives for older people to stay in employment

The number of 35-59 year olds is predicted to increase by 2.7 million over the period 1996-2006, while the numbers aged 25-34 will decrease by 1.9 million. Many mental health services have a high proportion of employees in their fifties who may be tempted to retire early. The level of early retirement throughout the public sector has been a cause for concern in recent years. For instance, one recent research study found that almost 25% of doctors employed in the NHS planned to retire early.⁶¹ This trend could diminish the impact of increasing the numbers of young people taking up training places.

Mental health staff in their fifties may choose to retire early for a range of personal and practical reasons. Some staff are simply dissatisfied with their jobs. Others take early retirement due to ill health. The Treasury announced a review of the level of ill-health retirement in the public sector in 1999.

As the proportion of older people in the population – and the labour force – continues to grow, eldercare will become as important as childcare as a factor which can inhibit employment. Many people in their fifties shoulder the significant burden of caring for their own parents or elderly relatives. This is not only a financial responsibility. As with childcare, organising eldercare takes up time and energy. Unless supportive policies are in place, many older mental health staff may feel that their arrangements are too complicated and stressful to sustain.

People with eldercare responsibilities, like some of the other older employees who consider early retirement, might like to stay in their jobs if they could change their work role. As things stand, this might jeopardise the pension rights built up over a lifetime of work because the NHS pension scheme is based on their last three years' salary. This is clearly a great disincentive for staff to alter their work commitment and reduce their level of pay towards the end of their careers although part time working is not effected in this way.

Priority issues for increasing the incentives for older people to remain in the mental health workforce include:

- identifying the factors that contribute to job satisfaction for this group;
- addressing elements of the job which may lead to, or aggravate, ill health;
- recognising the increasing importance of eldercare issues;
- looking at current pension arrangements.

There is also wider scope for creativity in finding the best way of utilising the experience of older people, including targeting this group as the source of untrained support workers and volunteers.

3 Attracting women into the workforce and improving the work-life balance

The proportion of women in the workforce continues to increase: women make up 1.1 million of the predicted increase in the labour market of 1.4 million between 1996-2006. Employers have become increasingly motivated to introduce what have been known as family friendly policies. Such practices now tend to be drawn together under the umbrella term “work-life balance”. This signals the recognition that many fathers as well as mothers, not to mention people who do not have children, have become unhappy with working hours and other conditions of work.

Working hours in the UK are still the longest in Europe. This continues to be a threat not only to family life, but also to the ability to have a healthy life. One broad swathe of health policy in recent years has focused on the importance of health promotion and the prevention of ill health. Mental health is of course included in this aspiration. All employers, including the employers of staff who happen to work in mental health services, must support the healthy work-life balance of their employees. The provision of flexible working arrangements for people with responsibilities for childcare and eldercare is part of the necessary strategy for improving work-life balance.

Mental health services have many female employees and also have severe problems with recruitment and retention. In this context, it is very clearly to employers’ advantage to provide the most extensive possible support for people who need or prefer flexible working arrangements.

One important sub-group within the larger group of women who may be attracted to, or retained within, mental health work is formed by women who are returning to the workforce after a career break. Many mental health services will already have advertising and recruitment campaigns aimed at women returners.

There has been some debate in recent years about the size of the pool of returners to nursing as a whole. In the absence of comprehensive data on the current position for mental health nursing, it is difficult to say how large a pool of returners may be available.

There is, however, anecdotal evidence that some women returners opt for bank and agency work because it offers more flexibility and better rates of pay. In so doing, some experienced and highly competent staff are removing themselves from the mainstream activity of mental health teams. This is a loss for the teams and the wider service, and ultimately, of course, for those who use the service. It may also be a loss for the women. They lose out on the benefits of being a recognised member of a team, and a permanent employee in an organisation.

Priority issues for increasing the incentives for women to return to, or join, the mental health workforce include:

- providing flexible working options and family friendly policies, including support for childcare and eldercare responsibilities;
- improving the work-life balance;
- targeting advertising and recruitment campaigns at women returners;
- ensuring that there are incentives for women to return as permanent mental health staff.

4 Competing for younger people as recruits to the mental health workforce

In 1998 there were 3.67 million 15-19 year olds and 3.52 million 20-24 year olds. These numbers are set to increase by 5% and 8.6% respectively by the year 2003, with the rate of increase slowing down towards the year 2008. This represents a significant growth in a group which can be targeted in recruitment and training initiatives.

Many of the school leavers who might in the past have entered training for a career in healthcare are now likely to go to university. They may still choose health training after this, but in some cases they may be less attracted to the practical side of healthcare work. School leavers who do go straight into healthcare training, however, sometimes lack the necessary skills. Although the qualifications held by new entrants to the workforce have increased significantly over the last 10-15 years, there are still shortfalls in the basic skills of many school leavers.

The NHS has been promised extra resources to tackle some of the current staff shortages, but this expansion follows a period when education numbers have reduced. In 1994/95 the entrants to pre-registration nursing training had fallen by over 25% from the 1989/90 level, although they have since improved.⁶²

Some of the managers we spoke to in the course of the review thought that the provision of free or subsidised accommodation in the past had been a significant incentive for choosing nursing as a career. They pointed out that the change in accommodation arrangements for student nurses was a powerful disincentive, and that student nurses now face the same pressures of funding and accommodation costs as other students. All the nursing staff we spoke to who were based in the South and South East of England said that accommodation costs were a major problem for them.

As mentioned in Chapter 2, the Government is currently reviewing the options for helping nurses with their accommodation.

There is also concern that potential entrants to training may be discouraged by the external reputation of the NHS as an employer. This negative image is a particular problem for mental health services, which tend to absorb the stigma surrounding mental illness in the media.⁶³ Many of the staff we spoke to in the course of the review felt that mental health nursing was seen as a job with low pay and low status but with high levels of stress and risk.

One nurse who had worked in child and adolescent mental health services had set up a schools' programme and gone into local schools to talk to 13-16 year olds about their mental health. There was enthusiasm about this initiative. It was felt that this approach could be very helpful in reducing the negative public image of mental illness, and, perhaps, attracting people into considering mental health as a career area.

Priority issues for consideration are:

- increasing the match between what younger people want from vocational training, and what their future employers will want from them;
- tackling the stigma of mental illness and mental health work through an information strategy targeted at schools and young people;
- seizing any opportunities to provide better support with accommodation for people in training, or who are newly qualified.

5 Growth of the service sector and decline of traditional industrial jobs

Training for mental health work is not simply of relevance to school leavers and young graduates. One of the key changes in the labour market in recent years has been the decline in traditional industrial jobs and the growth in the numbers of economically inactive able-bodied males of working age (currently about 2.3 million). Many of these men may have a great deal to offer to mental health work, and may gain much satisfaction from it. For this group of potential workers, the mental health sector is likely to compete with sectors which do not require so much training – for example, the growth area of call centres.

The key question here concerns how to attract people into making the commitment to retraining for a radical career change. People in this group of potential recruits are in a very different position from young people with relatively few financial and family commitments. They need support, and powerful incentives, including being convinced that mental health work will meet their expectations as an interesting and satisfying career change.

There has been a steady reduction in skilled and unskilled manual work in the last 25 years, but the training and education agenda has not kept pace with this trend. There is an excess of supply

for lower skilled jobs, but shortages in the supply for higher skilled jobs. Many of the men who have traditionally worked in lower skilled jobs will need to increase their skills. There is also demand for more skills within jobs, including computer literacy skills and customer handling skills.

Priority issues for this group are:

- promoting mental health work through an information strategy targeted at people who may be considering retraining;
- making it clear what support can be offered during training;
- developing incentives and motivators likely to enhance the attractions of mental health work for people who have worked in very different fields: for example, a package emphasising the innate interest and satisfaction of the work, the opportunity to acquire new skills, and the scope for working in effective teams.

Conclusions

There is growth in all the groups of people that we have discussed in this chapter, and there is potential for them to be targeted in strategies for increasing the numbers – and improving the diversity – of the mental health workforce. It is clear, however, that these groups need a powerful combination of support and incentives to attract them into mental health work. As we discuss in the next two chapters, however, some mental health services still have a long way to go in providing sufficient support to their current employees, and tend to miss the opportunities for building on existing incentives.

Introduction

Mental health work can be stressful even in an ideal setting. As it is, many mental health staff are struggling to provide a safe and high quality service in the face of understaffing, poor premises, and low morale. They are concerned about the risk of violence, and disorientated by the changes in ways of working. Some staff feel dispossessed of their professional roles and autonomy. They may also feel a sense of professional stagnation as promotion prospects recede, and hard-pressed managers find it difficult to secure the time for training, development, and team-building.

In this chapter – based on our discussions with front-line staff, and a wider context of recent reports and anecdotal evidence – we look at some of these problems. Some of the current pressures on mental health services, and the people who work in them, do seem to be caused directly by understaffing and poor retention. Other pressures – such as increased paperwork or concerns about violence – have different roots.

It is arguable, however, that some of these other pressures could be relieved by full staffing and improved retention. What is needed, in many cases, is more time – for training, development, risk assessment, and clinical supervision – but one of the main effects of staff shortages and high turnover is that time is lacking.

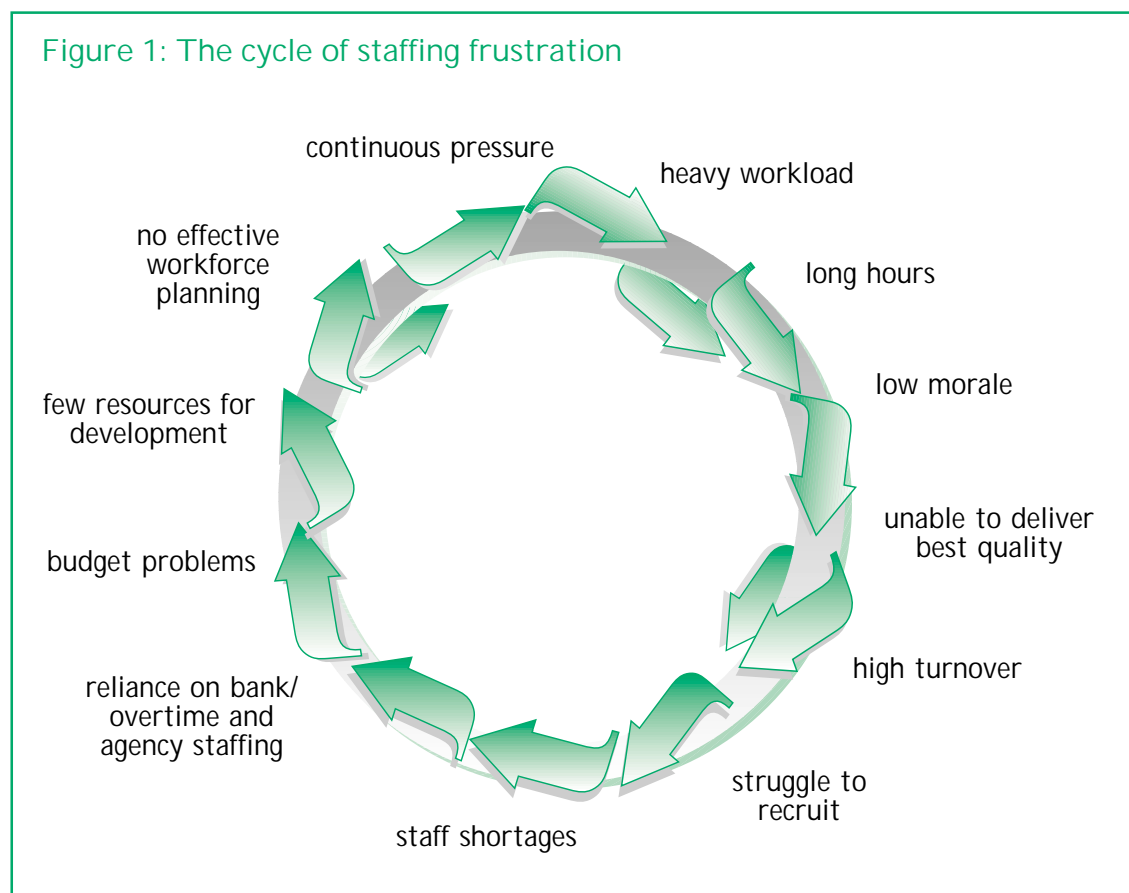
Key points

- Understaffing and high turnover affect the quality of care for users and send services into a vicious circle: they do not have enough time, or enough permanent staff, to improve their practice – but this makes the permanent staff they do have feel hard-pressed and reluctant to stay.
- Staff in mental health services are additionally burdened by long hours, excessive paperwork, and heavy caseloads.
- The risk of violence, and the grim physical environment in some mental health settings, are further causes of discontent and poor morale.
- The lack of opportunities for career progression, and the loss of role clarity and professional autonomy, are significant disincentives for staying in mental health work.

1 The impact of understaffing and high turnover

The cycle of staffing frustration

The figures on staff shortages and vacancies in Chapter 1 and Appendix 4 show clearly that mental health services face severe staffing problems. These problems have complex effects on a wide range of factors. Services tend to be forced into a vicious circle where the problems caused by understaffing or poor retention cannot be solved without more staff, and more settled and stable teams. This situation is stressful for managers, demoralising for staff, unsatisfactory for service users and their carers, and can place safety under threat. (See Figure 1, The cycle of staffing frustration).



Quality of care for service users

The continuity provided by staff remaining in post is important to people who use mental health services, including their carers. More widely, all of the quality issues which are adversely affected by poor retention and staff shortages have a direct effect on service users. This includes the level of morale in mental health teams. Burnout is defined partly by the impact of emotional exhaustion on face to face contact with clients.

Where there are staff shortages and over-reliance on agency staff, the focus of clinical care tends to be on providing a safe service rather than the quality of patient contact and the therapeutic

relationship. Other quality issues can then suffer. These concerns were raised by some of the practitioners we talked to during the review:

“people are constantly being pressurised to do work that we haven’t got time or space to do ... people don’t get a very good service ... it’s all being watered down from prevention to crisis work.”

With a full and stable staff complement, teams are well placed to deliver the comprehensive service which may otherwise remain merely an aspiration. Although this is partly a matter of staffing levels, it is also a matter of time. If all the members of the team, and their managers, are rushing constantly and find themselves barely able to deliver essential service elements, there are many desirable elements of their work which cannot be given any time. These are often elements which are not only desirable in terms of the quality and effectiveness of the service, but also precisely those elements of day to day practice which make these jobs desirable to the people doing them.

Time for team development

For example, there may be no time for reflection and team development. Given the importance of team working in mental health services, and the difficulties which have been encountered in developing teams, this is an important point. High turnover is destabilising to teams, as people do not stay long enough for a strong team to be built.

Time for staff training and development

Similarly, individuals are often unable to pursue training courses or personal development because they cannot be released from their duties due to staff shortages. This is demoralising. In some mental health services, there is in any case insufficient funding for training. Training becomes a significant budgetary pressure if managers have to fund replacement staff to provide cover for staff who are absent on training courses.

Time for education in flexible and generic ways of working

Lack of opportunities for training and development slows down the rate at which staff are being educated in more flexible ways of working. This is important for developing services, but it also has a strong effect on how positive staff feel about their jobs and their careers.

Time for partnership working

Teams and their leaders are expected to develop partnership working with a wide range of other agencies, but this also requires more time than is often available. These development areas cannot be crammed into pockets of time snatched under intolerable pressure. Cultural differences across the health, social care and independent sectors exacerbate this problem. Similarly, teams need to be able to review services and implement measured changes in their own organisation and practice.

Direct costs of unsuccessful recruitment and retention

There are considerable direct costs in having to cover staff vacancies and recruit new staff, including advertising costs, the cost of recruitment teams' work and time, and the induction of the new employee up to an effective level of working. The costs of these factors are between £5,000 and £10,000 per employee.

Over-reliance on agency bookings

Budgets are normally constructed for a stable workforce without staff shortages and high turnover, and are put under great pressure when recruitment and retention are not successful. Paying for agency staff is a significant direct cost.

There are also indirect costs. It is frustrating for permanent staff and for the users of the service if the agency staff are continually changing. Agency staff are of limited value if they do not know the local procedures and practices – and, if this is the case, then the organisation is paying too much for too little. Permanent staff sometimes feel resentful that agency staff are being paid at a higher rate, but without having to carry the responsibility. The quality of agency staff can also cause problems. If they are not competent, they may need to be given more restricted duties, thus making the service of even less value for money.

Long hours

For services to function safely, permanent staff often need to work extra hours on a bank or overtime basis. The combination of heavy workloads and long hours is stressful and demoralising, and can cause resentment about the erosion of life outside work. It may also increase sickness absence, which then places greater pressure on budgets as replacements need to be funded.

2 Wider causes of pressure on staff in mental health services

Even when services are not experiencing significant staff shortages and high turnover, staff working in mental health services can be subject to overwhelming pressure and highly stressful working conditions.

Heavy workloads

The amount of casework for clinical staff, and the inability to control workloads, were major concerns for the clinical staff we interviewed in the course of this review. In one trust we visited it was more difficult to recruit staff to work in the community than on the wards – despite grades being higher – because workloads were too demanding.

Heavy workloads cause problems across all the staff groups in mental health services. For example, the Professions Allied to Medicine Review Body recently found broad agreement among managers and staff that workload, roles and responsibilities were increasing.⁶⁴ Shorter stays in

hospital make patients more dependent on community staff in professions allied to medicine, as well as increasing the intensity of work for staff in hospitals.

Increased paperwork and bureaucracy

Increased paperwork and bureaucracy is a major source of irritation for all staff. Even although some of the increased paperwork arises from tighter risk management, we found scepticism about whether these systems were leading to improvements. Different agencies had different bureaucratic structures and different requirements for paperwork which compounded the effort required from teams to respond.

Bureaucracy has been identified as a major pressure for social workers.⁶⁵ In one survey of social workers in teams targeting people with serious and complex mental health problems, 80% of the reported pressures related to dealing with bureaucracy and the lack of time to complete paperwork. Respondents' comments suggested that changes in the volume of their work and in administrative systems have not been accompanied by the necessary changes in managers' perceptions of their roles. For example, in spite of brokerage and liaison with other agencies now being central to many practitioners' jobs, managers continue to assess their activity in terms of the number of their face to face contacts with clients.

Administrative support

Good quality administrative support is essential for both clinical teams and senior clinicians. IT systems need to be reliable and suited to clinical needs. In the services we visited, frustration was expressed at the inadequate level and inefficiency of administrative and IT support. For example, in one trust the community teams were not on the email network because of financial constraints. Because pay for administrative and secretarial personnel is low, there are difficulties recruiting staff who have the necessary skills. There is also a lack of in-house training to enable staff to gain the skills required to use new technology.

Stressful conditions in acute wards

Acute Problems, the recent Sainsbury Centre for Mental Health study of the quality of care in acute psychiatric wards, found that staff are facing unprecedented demands.⁶⁶ They are treating more patients against their will and these patients are more likely to present a risk to themselves, other patients and staff. Many inpatient wards are severely overcrowded and operating with bed occupancy levels well above what is accepted as safe. Within this context, care provision has to be provided by very pressurised and scarce staff to people suffering from the most severe mental health problems.

The report of the Standing Nursing and Midwifery Advisory Committee in 1999 also reported concerns about the quality of work life for mental health nurses:

“The picture of mental health nursing in acute settings is often of a demoralised group with ineffective clinical leadership, inadequately prepared staff in terms of education and training, with patently inadequate support from the other professional groups and administrative staff. Left unchecked the current situation would seem destined to deteriorate as problems of recruitment and retention will inevitably lead to further staff shortages. Lack of staff increases the risk of injury or harm to patients and staff and makes it difficult to replace custodial care with active therapy and rehabilitation.”⁶⁷

Staff interviewed for this review also spoke of the increased risks of violence to staff by highly disturbed patients, often with combined mental health and drug / alcohol problems. Nurses said that they did not feel adequately trained to care for people with this combination of problems.

Some of the nurses we spoke to in the course of the review did not feel that managers understood the difficulties they faced. Importantly – and this will be covered in more detail below – they also felt that their welfare and safety were not given adequate attention:

“there’s no balance between nurses’ rights and patients’ rights ... if nurses get assaulted we’re expected to take it.”

The risk of violence and concerns about risk management

Violence against staff is a growing problem in the NHS. In 1998 the NHS Executive found that there were 65,000 violent incidents against staff each year, and seven incidents per month per 1,000 staff. Recorded incidents were highest in mental health and learning disabilities, with nursing staff more than twice as likely as all other staff to be involved in a violent incident.⁶⁸ In 1999 mental health and learning disability trusts reported a rate of 24 violent incidents per 1,000 staff per month.⁶⁹

There are increasing anxieties about how risk should be managed in mental health care, and who is to be held accountable. There is, as a minimum, some conflict between good practice (empowering people to take risks) and legal and cultural environments (possible punishment for getting it wrong) which is felt most acutely on the front line.

The preparation of mental health care workers to respond to these pressures has been criticised. A recent research study has found that nursing staff are not always trained properly in the management of aggression. Staff may not be confident in their abilities to use the techniques they have been taught, which increases the risk both to themselves and the patients. Post-incident debriefing – which should happen in all cases – did not take place in a quarter of the cases examined.⁷⁰

It is well recognised that there are fewer violent incidents in services which are managed effectively and retain a strong focus on patients. When a violent incident does take place, it has a damaging effect not only on the individuals involved, but also on the wider organisation. As well as

physical injury, the member of staff can experience subsequent trauma and anxiety. Confidence may be so severely dented that staff decide to leave mental health work altogether.

For the organisation as a whole, there is disruption caused by the incident and its aftermath. An absent staff member may have to be replaced temporarily and expensively. Staff morale can be damaged, particularly if there are repeated incidents, and if there is inadequate support by the organisation. This can contribute to increased turnover, high stress levels, and difficulties in recruiting if the service becomes known for violence.

The risk of violence has always been present in mental health work – but employers run risks of their own if they seem to condone violence against staff as just part of the job.

Taking the blame

Following tragic incidents of violence or suicide, the staff involved are likely to be on the receiving end of intense public scrutiny about what was done in delivering care to the patient. Services are subjected to time-consuming inquiries and audits, which are sometimes perceived as hostile. This “blame culture” can lead to defensive practice – which is not necessarily in the public interest – and intense pressure on individuals. If this culture is sustained, it will take an increasing toll in terms of the demoralisation of staff. Many good people may be deterred from working, or continuing to work, in mental health services.

Poor physical working environment

Inpatient settings were described as generally “bleak” with poor physical facilities and an atmosphere of “demoralised disinterest” in the services we visited during the review. Therapeutic activities were minimal, and, in one trust, a consultant psychiatrist had written repeatedly to the Chair of the Trust about the “intolerable conditions” faced by inpatient nurses.

The poor physical environment within the acute mental health sector is one reason why some staff leave the acute sector to work in the community. It may also contribute to their decision to leave mental health work altogether.

The physical shortcomings of acute inpatient settings are well-documented. Most studies refer to this from the perspective of patients. However, the environment in most mental health wards is likely to have similar effects on staff.

112 patients were interviewed about their care and the ward environment as part of the Sainsbury Centre for Mental Health study of the acute psychiatric sector (*Acute Problems*, 1998). It was clear that inpatient care is very unpopular, and that many wards lack basic amenities. For example, 55% of patients had no separate bedroom, 71% had no secure locker for personal possessions, and 47% did not have access to a quiet area. Many patients feel unsafe on acute wards, and women patients are particularly dissatisfied. They have concerns about privacy and cleanliness, as well as their personal safety. Conditions on acute wards are especially poor in deprived areas.

These poor conditions on the wards, and patient perceptions of these shortcomings, also affect staff morale and retention in various ways. For example, it is frustrating for staff to have to spend time sorting out domestic matters rather than providing direct care to patients. If patients are themselves demoralised by the environment, they may project this onto staff – who are themselves suffering from a similar frustration with their grim and inadequate surroundings. Finally, working in this unpleasant environment makes staff feel undervalued. A feeling of hopelessness may cause their morale to sink still further, and the quality of their performance is likely to suffer.

3 Other sources of dissatisfaction among mental health staff

In addition to the pressures caused by understaffing, and the generally stressful conditions in some mental health services, there are some important wider sources of dissatisfaction. Broadly speaking, these relate to opportunities for career progression, and a sense of professional identity and status, including levels of pay.

Lack of opportunities for career progression for some staff groups

Many of the nurses and OTs we spoke to complained of the lack of opportunities to progress within clinical grades, and the lack of recognition for extra clinical skills gained. Current career opportunities for senior nurses and OTs are mainly into management positions. In many services, this has led to a “leaching” effect of experienced clinical staff. Nursing staff commented on the lack of posts that span the boundaries between clinical care and central trust management.

Some of the nurses and OTs who move into management positions in order to secure some career progression may be becoming managers for the wrong reasons. Their work as managers will be equally stressful, but they will have lost the satisfaction of seeing patients improve and being effective clinically. Mental health services need strong and effective leadership – but these leaders are likely to be drawn from people who would actively choose a management role, rather than opting for management because there is no other way of being promoted.

Loss of role clarity

Some nurses said that changes in service delivery and the move towards multi-disciplinary working had caused them to feel deskilled. Confusion of professional roles, and a more generic way of working, were a source of stress for many nurses and other professionals, notably OTs. The requirement for mental health staff to work more generically had initiated a difficult process in some trusts. In one trust we visited, there had been such a feeling of loss of professional identity among the nurses that the team manager had needed to “back track” to more defined professional roles.

OTs in particular felt that their professional role was neither understood nor respected, and that many OT posts had been filled by nurses.

Some of the social workers we interviewed spoke positively about multi-disciplinary working and saw it as a progressive and positive step towards the provision of better services –

“an opportunity to get involved and broaden out the social work role, for instance, getting involved in discussions around medication”.

On the other hand, some social workers were worried by the blurring of boundaries and feared that, in integrated teams, social workers might lose their autonomy and independence. There was particular hostility to the idea that social workers might receive clinical supervision by a health professional.

Some of the clinical psychologists we spoke to, similarly, felt that the position of the clinical psychology profession had to be “constantly defended”. Despite the need for multi-disciplinary team working, there was still a strong desire for clinical psychologists to be “autonomous in their practice”.

There were many comments that medical integration into teams was essential, but that some psychiatrists did not seem to be committed to this way of working.

There is a tension here – greater professional demarcation of roles runs counter to desired practice, but each professional group may be inclined to protect traditional roles and indeed has a responsibility to do so with profession specific skills. Although many of the professionals interviewed spoke positively of working in teams as an innately satisfying part of their jobs, it is clear that people need to feel valued and respected for their contribution to the team. They need to feel that their specific training and skills are both acknowledged and utilised.

Lack of clarity about the purpose of each service

Mental health services, and the people who work in them, are still struggling to define exactly what it is that they can offer. Some acute wards, as we discussed above, are becoming repositories for hugely disparate groups of patients. What is the precise purpose of these wards? Is the priority to provide a place of safety for acutely distressed patients – or do they aim to provide a therapeutic environment? From the point of view of staff, lack of clarity about the purpose of the service can be disorientating and stressful.

Low professional status

We found a sharp distinction between nurses and psychiatrists as regards a sense of professional status in the focus group discussions. Psychiatrists had concerns about psychiatry becoming too embroiled with the socio-political agenda, and the often “overwhelming” demands of their work, but they still considered their branch of medicine to be an exciting field of healthcare and one that they would recommend to others.

In contrast, virtually all of the nurses, despite many considering clinical work to be interesting, thought that nursing was now a poor choice of career. They considered that the public no longer respected nursing as a profession. Instead, the public image of mental health nursing was of a low paid and low status job, which was also highly stressful and perceived as increasingly dangerous.

Levels of pay

The issue of poor pay was raised predominantly by the nursing staff interviewed for this review and was seen as a further reflection of their work not being valued by society. The recent King's Fund survey into factors affecting the supply of nurses found that "poor pay" is having the greatest negative impact.⁷¹

Many of the nursing staff we spoke to who live and work in London and the South of England said that they were unable to afford the accommodation they required. Some of these nurses work extra hours as bank nurses to earn extra money, but resent being paid at the minimum set bank rate irrespective of their grade. Many staff said that poor pay by the NHS had led to an increasing proportion of nurses opting to work for agencies, which pay better hourly rates.

Managers face difficulties due to the difference in pay between local government and the NHS for posts with comparable roles – NHS rates of pay are generally lower than those in local government. This causes problems in integrated teams.

The need for strong leadership and management

In a much wider sense, the managers of mental health services are faced with a complex and daunting task. As noted above, line managers have often moved into management from clinical practice, and do not necessarily have prior experience to prepare them for this task. They need to be able to:

- fulfil several roles including business manager, personnel manager, team manager, coach and mentor, professional specialist, service champion and corporate player, and be sufficiently flexible to meet different agendas at different times, or at one and the same time;
- work with different agencies, sectors and practitioner-groups and their respective identities, ideologies and administrations;
- demonstrate their commitment to the organisation's espoused priorities, standards, values and roles;
- manage organisational, service and practice changes;
- provide clinical and managerial supervision and support to practitioners;
- manage careers and development, and expectations regarding these;
- manage conflicting priorities – such as developing staff and the service versus achieving business targets.^{72,73}

Much of the team-based service development in mental health places additional challenges before managers. Common trip wires for team managers include:

- describing the unit as a team but continuing to manage members as individuals;
- failing to exercise appropriate authority over the team and by default leaving it to clarify its own aims and operations;
- providing inadequate internal structures for operational management and leaving the team to work out the details;
- failing to provide organisational supports in the forms of rewards, training, information and the material resources needed to get the job done;
- assuming that members are already competent at working well in teams.⁷⁴

As we have discussed earlier in this chapter, the multi-disciplinary and inter-agency nature of mental health work leaves many teams with a lack of clarity about who is in charge, who will take the blame if things go wrong, and what precisely the role of each professional group now is. There is a need not only for strong leadership, but also for mental health staff to be developed as team players who are willing and able to be led in order to meet shared goals.

Conclusions

There are numerous pressures on staff in mental health services. Some are generated directly by understaffing and high turnover. Others arise from the wider conditions of the mental health sector – but all of the pressures exacerbate each other. If staff are generally discontented, and therefore decide to leave, this makes problems with recruitment and retention worse. If services are already under pressure because staff keep leaving, this makes all of the other pressures have an even worse effect.

This is only one side of the coin, however. In Chapter 5, we look at the more positive experiences of working in mental health services, and ask how these can be developed as incentives. We also look at the research evidence for an indication of how much importance should be accorded to staff attitudes, whether negative or positive.

Introduction

The previous chapter presents a disheartening picture of morale in mental health services, and of the multitude of pressures on staff. This raises some important questions.

Firstly, is the situation in mental health services quite as bad as it looks? What are the positive experiences of staff, and what do they value about their work? What are their main motivators, and how could these be built on in designing jobs and recruitment campaigns?

Secondly, to what extent does it matter if staff are dissatisfied in this way? In an ideal world, employers would like their employees to be happy in their work, but what is the real impact of the way employees feel about their jobs and their employers? If staff feel so negative that they resign from their posts, then this has a clear cost attached to it – but if staff are discontented in a more diffuse way, do their attitudes genuinely affect the performance of the organisation?

Key points

- Despite the many pressures of mental health work, staff gain satisfaction from seeing patients getting better, working in teams, and feeling that their contribution is valued.
- There is good research evidence that the more positively employees feel about their jobs, the better an organisation is likely to perform.

1 Positive aspects of mental health work

Opportunities for non-clinical work

Consultant psychiatrists we spoke to placed great weight on the balance of clinical and non-clinical work. They felt that the time set aside for research and teaching and professional development (and protected from erosion by day-to-day pressures) was an important contributor to job satisfaction.

Psychiatrists' commitment to working in teams

Despite other anecdotal reports that medical staff can be resistant to working as part of teams, many of the consultants we spoke to regarded teamworking with high calibre colleagues from other professions as an important and satisfying part of their work.

The appeal of psychiatry for doctors in training

Despite an average working week of 60-65 hours, morale among doctors in training was relatively high. Some had chosen psychiatry because of the interesting and complex nature of mental health problems. There were also comments that psychiatry was less hierarchical than some other areas of medicine, and that this was an attraction.

More positive experiences for nurses in suburban and rural services

In one inner city NHS trust, only one out of four nurses said that if they were starting their careers now, they would still choose nursing. In contrast, staff we spoke to in suburban and rural areas had a much more positive view of their work.

Satisfaction from good teamwork and seeing patients getting better

Nurses said that they gained most satisfaction from clinical contact with patients and “seeing them move on”. Good teamwork with skilled colleagues was also mentioned by many staff as being a very positive aspect of their work. Some staff spoke of having an excellent team manager as a source of job satisfaction.

The need for autonomy and control

Some of the managers we spoke to thought that there were fewer problems with recruiting community mental health nurses because they have more professional autonomy. It was considered that the main incentives in mental health nursing are job satisfaction and autonomy – or seeing people get well, and having control over caseloads. Staff working in inpatient environments cannot achieve this control:

“if you’ve got twenty five acutely ill patients on a ward and if there are only two qualified staff on duty, that’s stressful.”

The attraction of therapeutic mental health work for social workers

Many of the social workers we interviewed had previously worked in childcare services, and had wanted to move on when they felt that practice became bureaucratic and defensive. It was perceived, however, that this was now happening in mental health services. Nonetheless, social work managers identified several positive aspects of their choice to opt for mental health work – “a chance to develop a service ... mental health was a poor relation”. They valued the opportunity for multi-disciplinary and partnership working, and the scope for more therapeutic practice than would be possible in many other areas of social work – “You can see social work making a difference to someone’s life”.

Social work managers were asked what they enjoyed about being a manager. One positive aspect was having an overview of all clients in the area, rather than just a caseload. The challenge of being able to turn a vision into a reality was valued, although it could be frustrating when resources fell

short. Undertaking developmental work was seen as positive, but paperwork was a continuing problem.

Clinical psychologists: the attractions of therapeutic practice and professional autonomy

For some of the clinical psychologists we met, the main reason for having chosen, and stayed with, clinical psychology as a career was the level of contact with people, and the opportunity for therapeutic practice. There was some concern about the perceived need to protect professional autonomy while working in teams. Positive aspects of work seemed to focus less on multi-professional teams, and more on relations with the clinical psychology profession – for instance, peer support and supervision were mentioned as positive features of work.

Occupational therapists: the need for role clarity and the satisfaction of clinical effectiveness

OTs also mentioned their need for contact with their own profession, and concerns about role clarity. They expressed enthusiasm for the job, and said that job satisfaction was gained largely from “seeing people achieving something”.

Incentives for working in the independent sector

We undertook one visit to a hospital in the independent sector. Morale among staff seemed to be high. The level of pay was only slightly higher than in the NHS. Staff seemed to feel that this was a working environment in which each person’s contribution, whether professional or non-professional, was valued and respected:

“We’re all a multi-disciplinary team and we are all recognised for what we do ... everyone respects each other and everyone is on first name terms.”

There was a budget for social activities – such as teams going out to supper together. If a member of staff was assaulted, there was a policy that flowers should be sent. Following any critical incident, the member of staff is contacted at home to find out how they are:

“we are in a caring environment and are expected to care all the time for the patients, but if staff feel that management are always lashing out at them, this will feed down to the patients.”

This organisation appeared to have established an organisational culture which persuaded staff that they were valued. This is not a sense which emerges from our meetings with staff in the NHS and social services.

The main motivators for mental health staff

What does emerge, however, is a strong feeling of innate satisfaction in aspects of their work in spite of the pressures, the understaffing, and staff scepticism about the organisation’s commitment

to their welfare. Key contributors to satisfaction were:

- working in teams when teams are working well;
- being effective clinically and seeing some improvement in clients;
- having professional autonomy, or, at the least, feeling that a distinctive contribution to the team's work is recognised and valued;
- developmental opportunities.

In addition, there was a strong sense that staff were motivated to come into mental health work in the first place in order to be of service to the community, and to make a difference in the lives of vulnerable people.

The comments relating to team working suggest that time devoted to team development will be time well spent. Workloads also need to be managed actively so that staff do have as much clinical contact with patients as possible.

Protecting professional autonomy and role clarity is more problematic. Mental health services are moving towards more flexible and generic ways of working, and staff will have to make some sacrifices of professional autonomy along the line. Clearly, it is a priority to maximise the ways of supporting and training staff during this transition.

2 The effect of employees' attitudes on organisational performance

A considerable body of research has focused on the relationship between employees' attitudes and the profitability and productivity of organisations. Some of the most salient research is summarised in Appendix 5. The key points of relevance to this review are set out below.

There is good research evidence that how employees feel about their work, and how they are managed, make a significant difference to organisational outcomes and costs. This includes the quality of experience of those who use the organisation's services.

The more satisfied employees are with their jobs, and the more committed they are to the organisation, the better the organisation is likely to perform. To the exclusion of any other element of organisational culture, human factors have been found to predict differences between organisations' performance. These human factors include the extent to which employees:

- feel valued, trusted, and supported;
- are enabled to exercise a high degree of autonomy in undertaking their work roles;
- are well supervised and trained.

The following human factors also have an impact on organisational performance:

- attitudes to individual workload;

- attitudes to working in teams;
- belief in the organisation's provision of training and development;
- belief in the fairness of pay;
- belief in the organisation's concern with welfare.

Which HR practices have most impact on organisational performance?

What are the management practices most likely to promote the human factors which have a positive effect on an organisation's performance? One of the main studies looking at this question focused on NHS trusts.⁷⁵ It found that the implementation of each individual practice in human resources management (HRM) did not have a consistent impact on organisational performance, but that the effects of the full complement of HRM practices were more consistent. While certain HRM practices are clearly influential, there is no research-based consensus regarding best HRM practice, either singly or in combination.

In brief, there is good research evidence that an organisation's performance is likely to suffer if staff are dissatisfied and lacking in commitment, but it is not clear which management practices, in which combination, can be used to counter these negative effects.

Conclusions

It is expected that mental health services should improve their practice and assess their performance through increasing reference to the views and experiences of service users and their carers. In parallel with this agenda, it is clear that the attitudes of the staff who work in mental health services will also have to be accorded more weight than in the past.

Staff who do not like their jobs are more likely to leave or to retire early. At a more complex level, staff can be regarded as a key set of stakeholders in mental health services. The better they feel about the services in which they work, the more effectively those services are likely to perform.

What is at stake here is not simply the numbers of staff available in the mental health workforce, but the extent to which those staff feel motivated and satisfied in their work. Underlying this, there is an increasingly recognised need for all employers – including employers of people who happen to work in mental health services – to protect the health and promote the well-being of their workforce.

PART II

SOLUTIONS

TO

PROBLEMS

WITH

RECRUITMENT

AND

RETENTION

INTRODUCTION TO PART II

In Part I of this report we have established that there are serious shortages of mental health staff across all the professional groups, in terms of both numbers and skills. The Government recognises this. There are numerous relevant initiatives which may help to support the entry, or return, to the workforce by key groups – such as older people, women returners, young people entering training, and people considering retraining in mid-career. Recent policy for the NHS has focused on workforce planning and developing a more coherent HR strategy. The NSF for Mental Health also offers guidance and support on problems with recruitment and retention, whilst making it clear that more staff will be needed – and quickly.

This guidance and support is welcome, but local agencies will need to negotiate some tricky issues in order to build realistic and sustainable plans for improvement. For many hard-pressed services, however, it may seem almost impossible to stand back from current staff shortages sufficiently to start making any changes in recruitment and retention policies. As we have discussed in Chapter 4, one of the key effects of understaffing and high turnover is to deprive mental health services of the necessary time to take stock and take action.

Equally, the pressures we have described in Chapter 4 are an integral part of the problem. Measures to improve recruitment and retention are unlikely to be effective if all of these other problems and dissatisfactions are permitted to remain. Recruitment and retention need to be tackled as part of a broader strategic approach which also allows these related issues to be attacked.

At one level, this may make the situation seem even more desperate – how can any improvements in recruitment and retention be secured if all the ills of the system have to be confronted at one and the same time? At another level, however, seeing problems with recruitment and retention as part of a wider set of problems allows a more straightforward approach. It encourages a whole systems view. What elements of the whole employment environment make mental health work unattractive to actual or potential recruits, and how can these be changed?

Mental health work can be innately difficult and stressful, especially if the level of resources in the service is not adequate. Quite apart from these factors, however, much of the material we have looked at in Part I suggests that many mental health employers are not the kinds of employers

that their staff would like them to be. What exactly is lacking? What should mental health services be aiming for? What is the vision that is needed to transform current employment and management practice into something more attractive and supportive? What practical steps can be taken to drive the process of change?

In the following chapters, we aim to provide tools and instruments for thinking about these questions and developing local strategies. In Chapter 6, we propose a strategic framework for making management and employment practice more attractive and supportive. In Chapter 7, we look at tactics for addressing specific issues and tackling particular problems. Chapter 8 provides support for thinking through local priorities and developing a local strategy. In Chapter 9, we summarise our core conclusions and set out twelve recommendations.

Introduction

An increase in the supply of appropriately trained and skilled staff for mental health services cannot happen immediately. As we discussed in Chapter 2, we welcome the proposals for strengthening workforce planning set out in *A Health Service of all the talents*. We also welcome the strategic focus of *Working Together*, which aims to improve the quality of working life for staff, create healthier workplaces, and address the management capacity to deliver the HR agenda. These policy initiatives provide an essential structure for focusing more sharply on the distinct issues facing mental health services.

We believe that there is much that can be done now to change the context within which staff are being recruited and employed. We have identified three key questions for developing a whole systems view of the issue. These questions are concerned with the attractiveness of mental health work, the pressures on staff, the levels of morale and burnout, and the need for stronger leadership. The overall aim of the strategic framework should be to strengthen the structures of good employment and good management practice.

Key questions

- 1 Attract and retain: how can mental health services become more attractive to potential and actual recruits?
- 2 Lead and inspire: how can mental health employers create stronger leadership, more effective management, and an organisational culture that is sufficiently robust for the whole range of mental health service settings?
- 3 Support and sustain: what can be done to support mental health staff better and to promote and protect their mental and physical health and well-being?

1 Attract and retain

Question: How can mental health services become more attractive to potential and actual recruits?

Strategic approach: Ensure that HR strategy is at the heart of the wider organisational strategy.

We have focused on the HR function as the first element in our strategic framework. The HR function provides a crucial interface between employers and employees. This is relevant during recruitment, induction, training and development, and the agreement of pay and conditions. HR managers are able to offer expert advice on job design, sustaining interest and variety, and countering the effects of occupational stress and burnout. When an employee leaves, it is HR management which is best placed to capture and analyse their reasons for leaving through exit interviews or questionnaires. HR management is also in a good position to lobby for the changes which are essential for improved recruitment and retention – better opportunities for flexible working, improved physical working environment, and robust policies on violence against staff.

In brief, the interface provided by the HR function allows employers to generate and sustain a productive organisational culture. This may improve retention and enhance employee commitment. This interface also allows employees to communicate what they do not like about their jobs so that adjustments can be made.

Annual budgets in mental health services will normally be 70-75% staff costs. There is good evidence that HR issues have real impact on organisational performance (see Appendix 5), and yet HR departments still occupy a peripheral position in some mental health services.

The relationship between HR strategy and wider organisational strategy is the subject of considerable debate in the literature on HR. As Ulrich noted in 1998,

“the fact remains: the activities of HR appear to be – and often are – disconnected from the real work of the organisation.”⁷⁶

Ulrich argued that the HR function needs to become:

- a partner with senior and line managers in strategy planning and strategy execution;
- expert in understanding the business and the way work is organised and executed;
- a champion for employees, their commitment to the organisation, and their ability to deliver results;
- an agent in continuous transformation, shaping processes and a culture that together improve the organisation's capacity to change.

Strategic HR management aims to integrate HR practice with organisational strategy, and to ensure that HR policies are accepted and used by managers and employees as part of their everyday work.⁷⁷

Commentators have identified five main strands of activity in developing a strategic HR management environment:

- 1 integrating HR strategy with the organisation's strategic and business plans;
- 2 developing a coherent and consistent set of employment policies;
- 3 gaining employee commitment – both the commitment to pursue certain goals, and the identification with the organisation and its mission;
- 4 achieving high levels of competence at all levels of management;
- 5 creating a strong and effective HR function.^{78,79}

There are several options for improving the HR function in mental health services. In the first instance, we see the availability of sufficient numbers of high quality and professionally qualified HR managers as an essential foundation for approaching the problems identified in this report. The important point, however, is that HR expertise should be available within mental health services, and accorded a central place within the organisational strategy. This expertise could well be developed within existing management structures, supported by HR guidance and training.

Experience shows that HR managers from different sectors tend not to be effective unless they are given a grounding in the distinctive features of mental health services. Providing the HR function in these services requires:

- an understanding of the ethos and mode of operation in mental health services;
- a grasp of the professional skills of, and relationships between, mental health staff;
- sensitivity to the viewpoints of multiple stakeholders and the practical aspects of partnership working.

It is likely that a separate module of specialised training will be required to ensure that there are sufficient numbers of HR managers with this level of knowledge and expertise.

The central place of HR strategy and expertise can be threatened in two important respects. Firstly, people from the top of the organisation need to accord HR this central strategic position and genuinely incorporate these ideas in their planning systems.

Secondly, HR activity needs to be protected from being swamped in day-to-day demands so that a more strategic focus can be obtained. As things stand, many HR professionals – like other people working in mental health services – are very hard-pressed in trying to keep up with the policy agenda and a heavy workload. There is also an inherent tension between responding to immediate service demands, and making sure that staff are being developed and supported. If HR strategy is to contribute to the strategic framework for improving recruitment and retention, it is clear that HR professionals themselves will also need to be supported, and given strong leadership.

2 Lead and inspire

Question: How can mental health employers create stronger leadership, more effective management, and an organisational culture which is sufficiently robust for the whole range of mental health service settings?

Strategic approach: Promote high quality leadership and management of mental health services.

The major changes in the organisation and location of mental health services have left many staff with less clarity about their professional roles and about organisational culture, and added anxieties about issues of safety and risk management. They are also concerned about who will take the blame if things go wrong. Whilst some of these issues are structural, others reflect a lack of confidence in the various levels of management and supervision, and a need for clearer and stronger leadership.

Powerful and inspiring leadership of mental health services is an essential part of the strategic framework. Strong leadership overlaps with elements of HR strategy (see Section 1) while also channelling the organisational commitment to support and sustain staff in their roles (see Section 3).

Effective leaders and managers are expected to:

- provide good performance management;
- walk the job and get to know staff individually;
- make time for staff and be flexible in their approach;
- inspire good morale and team spirit;
- achieve flexible working arrangements;
- implement good workforce planning;
- pay attention to appropriate skill-mix initiatives;
- support training and development;
- redesign jobs to capitalise on what is rewarding to practitioners;
- offer active support for career development.

This is a complex task. Many mental health services do provide management training – either buying in standard packages or altering them to fit service management in mental health. However, few services systematically evaluate managers' ability to manage and lead staff. It is often said that people leave their managers rather than their jobs. This issue is clearly of central strategic importance in developing a framework for tackling problems with retention.

Leadership

Much has been written on good management and many of the wider aspects of good management are relevant to mental health services. However, in looking at the factors affecting recruitment and retention of the mental health workforce in the course of this review, we have given particular weight to the literature on leadership.^{80,81}

Leadership is a characteristic separate from management ability generally, which can be exercised by a variety of people at different times. Leaders can come from anywhere – they may be members of teams who take the lead in a particular initiative, or team leaders, or any managers right up to the head of the organisation. What is important is that they possess the power of creating an environment, mood or focus within a group of people which can then direct change or action.

An essential corollary of leadership is the willingness or ability in others to be led. Individuals may be willing to be led for a variety of reasons but usually because they perceive the leader to be able to direct action towards group goals while also delivering some benefit for them as individuals. An important aspect of leadership is the ability to motivate those who are led as well as defining the goals they will work towards. In order to manage change effectively, leaders in mental health must be able to deliver perceptible gains for the organisation, professional groups and individuals.

3 Support and sustain

Question: What can be done to support mental health staff better and to promote and protect their mental and physical health and well-being?

Strategic approach: Ensure that a mental health promotion strategy for staff is at the heart of the HR strategy.

Over and above good practice in the management of staff – by team leaders or by HR managers – there is a clear need to develop mental health workplaces as areas for mental health promotion. Mental health promotion should be an integral part of the wider HR strategy. What is needed is an overall framework which recognises the links between the mental and physical health of staff, organisational performance, and recruitment and retention. This is in line with a range of initiatives to improve health at work in the NHS.^{85,86} These have been developed as part of the ten year Health at Work in the NHS strategy (launched in 1992).

Many of the areas which might be addressed by a mental health promotion strategy – such as increasing role clarity, reducing paperwork, managing stress and improving job design – overlap with areas to be addressed by strengthening leadership and developing the HR management function. Similarly, some of the ways in which HR managers can work to reduce pressure on staff

Leadership and the mental health workforce

Leadership is important:

- to make potentially high risk decisions, often on inadequate evidence;
- to manage change effectively;
- to provide clear direction when required;
- to define the group or task as being intrinsically worthwhile and the goals as worthwhile and deliverable;
- to attract and retain good quality staff;
- to motivate staff;
- to deal with difficulties, including external barriers and internal poor performance;
- to reward – or be perceived as capable of rewarding – staff.

The key questions for the mental health workforce are:

- who will lead?
- what style of leadership is appropriate?
- how can leaders be selected and nurtured?
- how can an environment be created which enables leaders to be effective?

All these questions need consideration within the present mental health culture, which does not support clear leadership. The context is very unstable and tasks are often unclear. Staff have multiple lines of accountability to their professional groups, and to their managers and employers. The demands of different partner agencies can compound the problems. In the context of multi-disciplinary teams, leader-member relations are often poor, and the power position of leaders tends to be weak.

Who will lead?

This has always been a vexed question in mental health services, with all the main professions putting forward a case for exercising leadership. A crude debate about who is in charge will always be unproductive in an area like mental health where power is diffused and individuals possess different roles, competencies and experiences. No one profession or group can lead mental health services at all levels, in all settings and at all times.

What is important in this kind of environment is to define the precise roles and responsibilities of managers and professional leaders, and to nurture managers and staff who are capable of being led – often by someone from a different background – as well as being capable of leading. This will not be easy given the combination of defensiveness and professional *amour propre* which seems to exist in mental health professions.

What style of leadership is required?

The literature on leadership defines four main styles:⁸²

- exploitative-authoritative;
- benevolent-authoritative;
- consultative;
- participative-group.

The last is usually regarded as the most effective form of leadership. However, mental health services have much in common with what has been identified as an unfavourable leadership environment:⁸³

- diffuse or uncertain power structures;
- task structures sometimes unclear;
- cynicism or low morale;
- ambiguity.

According to thinking on leadership, these characteristics benefit from a task-oriented approach to leadership, and some mental health settings may require a degree of benevolent authoritarianism for a period in order to achieve change. Someone has to be responsible for making decisions about setting priorities and bringing the stakeholders on board. Priorities will not necessarily emerge from the “soup” of stakeholder views and aspirations.

This is not to say that the successful task-oriented leader will not pay a good deal of attention to the human relations aspects of achieving change. From the literature, however, it seems unlikely that simply importing someone’s idea of what constitutes good leadership into each and every mental health setting across the country will be productive. The style of leadership will need to match local needs and the local state of development.

How can leaders be selected and nurtured?

It is unrealistic to select for leadership ability at the entry level of the relevant disciplines, with the possible exception of senior management training schemes. Selection should, however, be built in as individuals move into more senior positions (starting at team leader level). The sorts of competencies which might be selected for, using a variety of techniques, could include:

- emotional intelligence;⁸⁴
- strategic thinking;
- valuing diversity;
- team working;
- effective representation;

- whole systems view;
- analytic ability;
- risk management/option appraisal;
- people management skills;
- achievement orientation.

These competencies are at least partly trainable. In addition, the following trainable competencies can be worked on as potential leaders move up the ladder:

- understanding of organisational and corporate governance issues;
- understanding of mental health issues;
- local knowledge;
- knowledge of policy;
- financial management;
- stress management (self and others).

These are only examples. However, it is clear that a successful strategy to nurture leadership is likely to consist of:

- 1 defining the required competencies for leadership in mental health services;
- 2 devising selection techniques and applying them at the right point in the cycle (probably not too early for fear of false negatives/screening out good quality practitioners);
- 3 devising a developmental programme to nurture a cadre of leaders across all the relevant professions;
- 4 creating an environment that encourages potential leaders to participate and to stay in mental health services.

are also part of a mental health promotion strategy. A successful strategy for tackling recruitment and retention problems will require the close bonding of these three mutually interdependent strategic approaches.

The need for a mental health promotion strategy for the mental health workforce

Many of the factors which influence both the physical and mental health of staff relate to style of management, working culture, levels of support, and job security. Several studies demonstrate the impact of organisational factors on individual health and suggest that working patterns may be a key source of stress.^{87,88,89}

A mental health promotion strategy aims to promote the mental well-being of staff and the organisation through initiatives which focus on areas where there is good evidence of mental health impact. These include:

- support for staff;
- effective communication;
- job control;
- the wider working environment, which includes both the physical environment and policies which have impact on the quality of working life – e.g. on discrimination, harassment, and bullying.^{90,91,92}

The Health Education Authority document *Framework for Action* identifies three stages for developing and sustaining staff health improvement, which can be adapted to accord greater priority to mental health:

- building support for staff mental health and well-being as strategic priorities;
- ensuring employment and management policies and practices promote staff mental health and well-being;
- developing the workplace as a setting for mental health promotion.

Conclusions

We have suggested a strategic framework which places HR strategy at the centre of organisational strategy, and a mental health promotion strategy for staff at the heart of HR strategy. The aim of this approach is to transform the employment environment so that it becomes more attractive and supportive. Overarching this, there is an urgent need to identify and develop people who have the capacity to lead mental health services.

Introduction

We have suggested a strategic framework in the previous chapter. In the course of the review we have also looked at numerous practical solutions, interventions, and suggestions which are targeted at particular problems or issues. We have already stressed the need to look at individual problems in the wider context of pressures on mental health staff, poor morale, and weak leadership. However, within this wider perspective, targeted tactics for dealing with specific issues have the potential to be highly effective.

To take one example – small changes in the mechanisms for making improvements to the physical environment of wards could have a significant impact on morale, which could then drive improvements in performance and retention.

The specific problems for resolution will be unique to each mental health service, but we have set out some of these practical steps – and identified some of the issues for consideration – as a starting point. For ease of reference, we have arranged this material alphabetically as An A-Z of interventions to improve recruitment and retention. Individual entries are cross-referenced with each other, and with the recommendations (see Chapter 9).

The list is not – and is not intended to be – a full or exhaustive list. We hope, however, that it will provide practical suggestions, and a checklist of the many and complex areas for examination.

An A-Z of interventions to improve recruitment and retention

- Contents
- A Advertising
- Appointment
- B Bureaucracy
- Burnout
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- Clarity of professional roles
- Culture
- D Developmental opportunities
- Devolved budgets
- E Eldercare
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- F Flexible working and family friendly policies
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- J Job design and job control
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- O Older people
- P Pay and benefits
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- Q Quality
- R Returning to work
- S Sickness absence
- Stress
- Support workers
- T Time for team development and time for training
- U Users of services
- V Volunteers
- W Work-life balance
- X EXit interviews
- Y Young people
- Z Zero tolerance of violence against staff

An A-Z of interventions to improve recruitment and retention

Advertising

Advertising campaigns can be targeted at certain key groups such as women returners, people considering retraining, and older people. For instance, there is anecdotal evidence that more mature people are less likely to drop out of pre-registration mental health nursing programmes, more likely to be sure of their career choice, and more likely to become stable employees.

Appointment

Much can be done to increase the match between new recruits' expectations and their jobs, and to minimise the chances of new recruits leaving soon after appointment.

- Ensure that job / person specifications accurately capture all roles and responsibilities.
- Provide realistic and accurate information about the work role and organisation.
- Make sure that short-listing methods are consistent with job / person specifications.
- Adopt a competence-based approach that focuses on the required mix of skills: this is useful in short-listing, and provides a structure for feedback to the candidate and organisation.
- Monitor new recruits effectively and respond to their views and performance.

Bureaucracy

The amount of bureaucracy and paperwork is a major cause of dissatisfaction and stress. Workloads need to be actively managed to maximise the amount of time spent in direct contact with patients: see Recommendation 10. Each employer should work towards simplifying and integrating procedures such as record keeping and care planning: see Recommendation 11. It is important to invest in IT and to review jobs to see if they are necessary in their present form or could be computerised. It is also important for partner agencies locally to develop common data sets and reporting systems and to eliminate double or triple demands for upward reporting.

Burnout

There are worrying levels of burnout in mental health teams. Some practical approaches to preventing burnout are set out below. Managers need to:

- be aware and responsive;
- plan time out for staff;
- offer counselling support;
- make physical activities available on site to improve stamina (e.g. exercise classes, swimming);
- make staff aware that the organisation is concerned about stress and burnout through leaflets and presentations;

- provide training courses on managing stress, and make sure that staff are released to attend;
- plan variety in individuals' jobs.

Career progression

Many staff feel unhappy with their prospects for moving on in their careers. This is demoralising and demotivating. Adequate time needs to be set aside for Continuing Professional Development and training; see Recommendation 8. In the absence of opportunities for being promoted to a higher grade, much can be done through enhancing wider development opportunities (q.v.) and lateral promotion (q.v.).

Clarity of professional roles

The blurring of professional boundaries is stressful and disorientating for some staff and can cause a withdrawal from team working in order to protect professional autonomy. This issue needs strong leadership (q.v.) and careful management so that staff are enabled to work as a team and to feel that each contribution is valued. Training and support is needed as staff move towards more generic and flexible roles (q.v.) and professional bodies should consider the requirement to include teamworking – particularly in multi-agency environments – in basic training.

Culture

All professions and agencies have their own ethos and culture built up over many years. When expressed in practical settings these can at times cause confusion and stress because they can lead to conflicting priorities and demands. Experienced and knowledgeable managers – clinicians, general managers and HR managers – should all be able to work with teams to reduce such tensions.

Developmental opportunities

Providing employees with opportunities for development can help to compensate for reduced opportunities for promotion and career progression (q.v.) and signal employers' commitment to employees. Personal Development Plans are a means of identifying and recording an individual's development needs. It is important to make sure that managers understand the value of development as a motivational tool. Responsibility for development plans needs to be clear, with line managers undertaking to support aspects of the plan that benefit both employee and employer.

Development options can be implemented without formal training. These need to be tailored to individual aptitude, preferred learning style and personal circumstances. Some ideas are listed in Resource Box 1.

Resource Box 1: Development options

- Attend regular grade-specific and topic related study days
- Undertake computer based learning
- Serve on a task force or working party
- Undertake a secondment to another organisation or within your organisation
- Get a mentor – identify a manager who is excellent at developing people
- Deputise for your manager or organise work shadowing
- Write a major report or a report summary or a book review
- Analyse the actions of effective leaders
- Undertake a sabbatical
- Represent your organisation or profession
- Work on a community project
- Keep a learning log or undertake guided reading
- Listen to cassette tapes on the move
- Visit other organisations
- Respond to all round feedback
- Use diagnostic instruments
- Join a user group
- Develop a staff network

Devolved Budgets

Managers should have the means and flexibility to remedy minor equipment and facility shortfalls. They should also be able to recruit in ways which are optimal for filling vacancies based on their experience of the unit or team.

Eldercare

Many mental health services have significant numbers of staff in their forties and fifties, for whom eldercare is a major problem. The need to care for elderly relatives may also inhibit potential middle-aged recruits. Flexible working options (q.v.) need to include support for people with eldercare responsibilities.

Environment

The physical working environment in many mental health services leaves much to be desired: some of the solutions to this problem will be long term and costly. In the short term, however, there are practical steps which can be taken, such as:

- delegating budgets for minor physical improvements to ward managers;
- involving staff in minor and major decisions about spending on the environment;
- providing mechanisms for staff feedback about conditions;
- ensuring a clear personal link between ward managers and facilities staff, perhaps with a hotline or similar mechanism to get problems fixed quickly;
- providing adequate staff facilities for staff on site and ensuring they are clean and functional, especially toilets, rest areas, canteens etc.

Flexible working and family friendly policies

The provision of flexible working options forms part of a wider strategy for promoting health, including mental health, in the workplace, and improving work-life balance. Key groups of staff will not be able to be recruited and retained if supportive and flexible working options are not available.

Resource Box 2 sets out some of the wide range of flexible working options in use.^{93,94} Resource Box 3 describes in more detail the use of flexible rosters in NHS trusts.

Resource Box 2: Flexible working options

| | |
|------------------------|---|
| Temporal flexibility | Shift working Overtime Flexi-time Part-time working Flexible working weeks Annual hours contracts Term-time contracts |
| Numerical flexibility | Outsourcing activities Engaging self-employed consultants Fixed period of temporary contracts Employing agency workers |
| Functional flexibility | Cross functional tasks Client centred work |
| Locational flexibility | Mobile work All or partly home based work |

Resource Box 3: Flexible rosters

Some NHS trusts have developed flexible rosters. The NHS Confederation, in conjunction with the Department of Health, assessed 19 pilot schemes supported by a Swedish computerised system called Time Care, and compared them with other trusts that had implemented flexible rosters.⁹⁵ They defined flexible rosters as *individual staff choosing the pattern they want to work while meeting the needs of the service*. Some of their key findings are set out below.

- 1 Most benefits were obtained where the project was part of HR organisational development, and was used to question and challenge assumptions about the traditional ways of employing and using staff.
- 2 The most successful sites had an integrated project plan that supported the service plan. For most organisations, moving to flexible rosters represented a significant change in working practices.
- 3 Many staff described the greatest benefit of flexible rosters as giving them greater control over their lives. While many had not changed their hours of work, they felt more able to do so when they wanted.
- 4 The advantages and disadvantages of flexible rosters need to be thought through and it is essential there are clear objectives and realistic expectations at the outset.
- 5 Flexible rosters are being supported successfully by both manual systems and computer based systems.
- 6 Parts of the NHS rely on the goodwill of staff in working over and above their contracted hours to cover staff shortages. Flexible rosters make this more noticeable by showing the accumulation of such hours. There was a perceived benefit to staff in showing the extent to which this extra working time occurred.
- 7 In implementing these systems there must be a balance between the needs of the individual and the organisation.
- 8 Flexible rosters only achieve benefits where there are good relationships and trust between all parties. Many staff work unsocial hours to gain the premium payments attached to those hours and can be suspicious of enforced flexibility.
- 9 As a result of flexible rosters there was a clear transfer of control of working hours from managers to staff. This was perceived as a benefit even when staff did not actually change their hours or shift patterns.

Generic working and flexible roles

Recent research by the Sainsbury Centre for Mental Health suggests that staff still work in highly traditional ways.⁹⁶ However, the NSF for Mental Health requires staff to work in a range of new ways and to develop advanced skills in specialist areas of practice. Evolving mental health services will require ever greater use of multi-professional teamwork, and the development of new interventions which require a synthesis of medical, behavioural and social models. This has important implications for professional roles and identities which need to be touched on in basic training.

New flexible roles are being developed which require staff to function both as generic mental health workers and advanced specialist practitioners. Staff need training and support during this transition. Some groups need to be reassured that the perceived loss of role clarity (q.v.) and professional autonomy will be balanced by other benefits.

In recruitment terms, services need to stipulate the competencies required of staff, as well as the discipline or profession. Core competencies for generic working will need to be identified.

Healthy workplaces

Mental health workplaces offer much scope for development as sites for the promotion of the mental and physical health of those who work there, and the prevention of ill health. This follows an important strand of policy initiatives. It also forms part of the strategic framework for tackling problems with recruitment and retention which we have identified in Chapter 6: see also Recommendation 12.

Plans for improving health at work need to address job design, the working environment, and individual responses to occupational stress through attention to:

- enhanced teamworking;
- better control over work;
- improved working environment;
- occupational health and counselling services;
- increased staff involvement;
- better communications;
- health promotion training for managers.

HR function

We have identified the development of the HR function in mental health services as a strategic priority in Chapter 6. This function provides a crucial interface between staff and employers. There is scope for developing the function through specialist HR guidance and support for team leaders and other managers, as well as increasing the numbers of professionally qualified HR managers in mental health services: see Recommendation 7. In either case, it is essential that HR professionals have a good understanding of the distinctive environment in mental health services. This may ultimately require the development of a new training module for HR professionals.

Induction

Thorough induction can be neglected in pressurised and understaffed services, but it is important to give new recruits (and those deployed in new posts) good initial experiences. This helps to minimise risks of disillusionment and early resignation.

- Plan and co-ordinate early induction for all new to the organisation and / or role.
- Be sure all elements of the job are made clear.
- Offer opportunities for learning.
- Make clear the expectations against which the quality and performance of the new recruit will be measured.
- Provide opportunities to meet key people.
- Make the map of the organisation clear.
- The use of mentors can facilitate induction.

Initiatives

Particularly when handed down from on high, these can be received poorly by front line staff who need time and stability to make services work. Any “initiatives” must be worked up in partnership with front-line staff and have their support if they are to succeed.

International recruitment

Staff from overseas have traditionally been an important part of the NHS workforce. In the present context of staff shortages, international recruitment is worth exploring further – although some foreign governments may (very understandably) see this as poaching their own trained workforce.

In general, international recruitment can fail if there is too little attention to preparation, communication, and good employment practice. Some of the lessons learned about international recruitment are summarised in Resource Box 4.

Job design and job control

Staff can be unhappy with the design of their jobs, but they can also be unsettled by slippage from the original design due to the many pressures on the service. In designing the job, there needs to be attention to:

- control
- responsibility
- variety
- opportunities to use skills

Resource Box 4: International recruitment

| | |
|---------------|--|
| Preparation | <p>Be realistic about what jobs are available for overseas staff</p> <p>Consider the appropriateness of grading when skills and experience clearly exceed those required</p> <p>Ensure managers are trained in understanding diversity and resolving misunderstandings or issues which can arise</p> |
| Accommodation | <p>Ensure that recruits have suitable and acceptable accommodation</p> <p>Arrange blocks of accommodation or shared accommodation for the first six months</p> <p>Waive accommodation fees for the first few months</p> <p>Provide welcome packs in rooms</p> |
| Finances | <p>Pay a relocation sum to international staff</p> <p>Have a sub-structure (e.g. payroll) in place ready for the new recruit to start or risk almost immediate loss</p> |
| Social | <p>Recruit in pairs or small groups</p> <p>Arrange arrival together or within the same week</p> <p>Offer induction to the local neighbourhood and not simply the trust</p> <p>Involve other trust staff in befriending and acclimatising</p> <p>Use senior staff as mentors</p> <p>Use previous recruits from the same country to act as ambassadors</p> <p>Consider whether practical information about the UK, its cultures and its professional practices is required</p> |

- challenge and autonomy
- boredom and dissatisfaction.

It is particularly important to monitor the aspects of the job that are related to stress:

- role overload – being asked to perform too many roles so that some are not performed adequately;
- role conflict – having to perform roles that compete directly;
- role ambiguity- being unclear or confused about what is expected.

Knowledge and experience

When staff leave, they take with them a valuable stock of knowledge and experience of particular patients, the organisation within which they have been working, and local issues such as helpful contacts and important boundaries. This cost – while difficult to measure – is considerable.

Lateral promotion

What can be done to reconcile staff to the loss of role clarity (q.v.) and compensate for the perceived lack of opportunity for career progression (q.v.)? There is scope for much creativity here in encouraging more movement between levels and functions so that people can develop their skills and experience. For example, lateral promotion schemes can be used to help to retain staff within their areas of competence. This enables staff to develop high levels of expertise in specific areas of competence – and for this to be acknowledged – but can also help to prevent burnout (q.v.) and boredom by enabling staff to develop a portfolio of competencies at various levels through lifelong learning.

Leadership

Mental health service managers are faced with a complex task in a pressurised and changing environment. The development of stronger leadership is part of the strategic framework that we have discussed in Chapter 6. Core competencies need to be established and selected for, and steps can be taken to develop a strategy for nurturing leadership across mental health services. Personal Development Plans and Training Strategies should also address management and leadership development for individual staff or staff groups: see Recommendation 9.

Strong leadership and effective management are essential levers for driving change and improvements in many of the aspects of day to day work which cause pressure and distress to mental health staff – such as lack of contact with patients and excessive paperwork.

Long hours

Staff shortages place pressure on all members of the team to work extra hours so that a safe service can be provided. This not only erodes the work-life balance (q.v.), but also increases the risk that staff will experience burnout (q.v.). Levels of sickness absence (q.v.) can also be increased. While there is scope for some management interventions to reduce the working of extra hours, this problem is likely to remain until staff shortages are reduced.

Morale and motivation

It is easy to associate morale with negativity and burnout in the mental health workforce – but much can be done to build on the many positive and rewarding aspects of mental health work. Understanding and analysing these positive elements is essential for improving job design (q.v.). The most commonly cited motivators seem to be:

- a fundamental belief in the value of public service and of helping others;
- being effective clinically and working with clients;
- working in teams;
- working with other disciplines;
- aspects of the job itself, including opportunities for innovation, variety and challenge;
- being valued;
- opportunities for professional development and training;
- having autonomy and power.

Different motivators may work for different staff groups. For highly trained practitioners, for example, the main motivators might be: career development; further professional qualifications; interesting and varied work; and good facilities. Specialists or experts may be additionally motivated by: peer recognition; opportunities to research and develop the field; academic links; and publication.

Non-clinical work

Although time for non-clinical work is often specified in job descriptions, in practice this time is easily eroded by the demands of clinical work and providing a safe service. This is demotivating for staff. Opportunities for interesting non-clinical work are powerful contributors to motivation (q.v.) – perhaps especially for doctors – and can also help to ensure more successful job design (q.v.) as well as reducing the chances of burnout (q.v.). Failure to protect time for non-clinical work will be a false economy if staff then become demotivated and ultimately decide to leave the service.

Nurseries and help with childcare costs

Workplace nurseries need to be carefully costed to ensure they are commercially viable. They need flexibility to accommodate workforce needs – e.g. late opening – and they need to be large enough to be commercially viable, perhaps taking up to 50 children. Staff may still expect some kind of subsidy from the employer. For example, if a nurse has to pay £120 per week per child and has two nursery age children, this amounts to costs of over £1,000 a month. Returning to work may then make no economic sense.

Workplace nurseries may not meet the requirements of many staff in any case. For instance, it might not seem viable to commute with young children into central London. More generally, any arrangement which necessitates moving children around during the late evening is disruptive.

Assisted childcare places will suit some parents better than workplace nurseries, but it will still be difficult to accommodate shift working. Ultimately, this is a matter where parents have to determine their own work-life balance, but there is much that employers can do to support these

choices. The more assistance offered with the more childcare options, the better. Staff can be consulted about what options they would find most helpful if they were available. This is also a pertinent issue to raise at exit interviews (q.v.). Finally, it is important to recognise that anxiety about childcare arrangements may contribute to occupational stress for some staff.

Older people

Many mental health services have significant numbers of staff in their fifties who may be tempted to take early retirement unless there are sufficient incentives in place. Many of these staff may have substantial commitments such as eldercare (q.v.). They may also be reluctant to stay in their jobs but change their work role because of concerns about their pensions (q.v.) – the NHS Pension Scheme is based on their final three years' salary: see Recommendation 6.

Older people are also an important group to target in recruitment, retraining initiatives, and as a source of volunteers (q.v.). More consideration needs to be given to the best ways of utilising the mature workforce: see Recommendation 5.

Pay and benefits

This review did not aim to deal with pay *per se*, but clearly pay is an important mechanism for recruiting, retaining and motivating staff. The crucial point in this context is that pay should be perceived as being fair. There is a tendency to attempt to deal with any recruitment deficit simply by raising pay rates – this is unlikely to succeed without attention to the numerous other factors we have identified. There may be most scope for developing pay in relation to performance as part of a system of skill development and reward. We look at some of the options in Resource Box 5.

Looking to the future, it may be that a group approach to pay awards would be most likely to succeed. For example, good performance could lead to an award for the team which could be used for purposes such as improving facilities or better team training events.

Pensions

Older people (q.v.) who might like to stay in employment but reduce their hours or level of responsibility, can be put off doing so by the NHS Pension Scheme, which is based on their final three years' salary: see Recommendation 6. There is scope not only for persuading staff not to take early retirement, but also for exploring ways of extending working life beyond retirement age.

Quality

Interventions to improve recruitment and retention and to target specific problems need to be seen as part of the wider strategy to improve quality in mental health services. This includes the quality of care provided for service users (q.v.), the quality of support for carers, and the quality of experience of the staff who work in mental health services.

Resource Box 5: Pay, performance and reward

Performance related pay

Performance related pay (PRP) is claimed to have a number of advantages in:

- rewarding staff performance;
- allowing discrimination between staff who have performed and those who have not;
- reflecting current market trends;
- allowing valued staff to be paid extra in order to keep them;
- providing a “top up” for staff who are at their maximum salary scale point.

However, there are some problematic issues for consideration:

- PRP requires a heavy management input and expectations have to be managed carefully;
- the tendency has been to use PRP for higher graded staff;
- even when a PRP scheme has little impact on performance it is difficult to remove it once it has been established;
- decentralisation of pay decisions was identified as one of the most time- consuming personnel issues for HR departments in a recent survey.⁹⁷ This was also the experience of HR directors in NHS trusts responding to the Health Service Report survey (1997);⁹⁸
- it is difficult to evaluate the impact of PRP because confounding factors (such as workload) are not measured;
- comparisons of the effectiveness of PRP are difficult to make because of the different approaches taken.

The conclusion of this review was that although well designed PRP schemes may have a limited role in certain circumstances – and only if the level of reward is sufficient – there is little to commend or support PRP schemes as a central way of recruiting and retaining mental health staff. Many of the features of mental health services, such as high pressures on management time and the importance of perceived fairness, argue against the introduction of PRP unless the rationale is crystal clear.

Clinical ladders

A clinical ladder is a term to describe “a grading structure which facilitates career progression by defining different levels of clinical and professional practice in nursing”.⁹⁹ Climbing the ladder requires individual

Returning to work

There are practical steps which can be taken to provide incentives for returning to work after a career break, and to offer support during the process. A significant pool of highly trained women is being lost to mental health services. Some of these women choose not to return to work at all, or to work in another sector which offers better pay and conditions. Others may opt for bank or

nurses to obtain and combine a range of clinical skills and excellent working practice, thus linking increased pay and increased individual performance.

Buchan and Thompson's 1997 study of clinical ladders found that they were perceived as increasing retention and enthusiasm of staff. There are disadvantages of clinical ladders, however. The cost of developing competencies and paying for staff training create a financial burden. To limit the financial burden a trust may face, limits on how many staff can gain promotion may have to be introduced. Such a rationing system may have a negative effect on staff – people may believe that they are not receiving promotion because the quota has already been met. An alternative method is to “ensure that the criteria for advancement at the ‘top end’ of the ladder are sufficiently difficult to limit advancement”.

As with PRP, the concept of clinical ladders may not be compatible with the ethos of the NHS and of mental health services. However, if staff are consulted throughout the process of introducing such a scheme, other benefits might arise. These include staff ownership of the scheme, and providing opportunities to develop competencies which are meaningful to them. As high quality research evidence is as yet lacking, clinical ladders cannot be recommended as a blanket solution to problems of retention.

Retention bonuses

Retention bonuses may be effective in encouraging an employee to defer the decision to leave, but, as with PRP and clinical ladders, retention bonuses need to be treated with caution as they have clear downsides.

Retention bonuses:

- can cause resentment among those who are ineligible or whose posts are ineligible;
- may be paid to individuals who are not at risk of leaving, or to individuals whom the organisation would not be sorry to lose;
- can result in an internal spiral of different constituents arguing that retention bonuses are necessary to avoid the loss of key people;
- can be rendered ineffective by other employers buying out these bonuses;
- can play havoc with internal relativities and the integrity of grading systems (unless the grounds of their payment are clear from the start – for example, are they attached to the post or the person?)

agency nursing because of the relative flexibility. In this case, they are not integrated into teams, and they lose the benefits of career development. Some lessons about offering practical support to returners are set out in Resource Box 6.

Resource Box 6: Support for returning to work

The South East London Consortium funded a project looking at return to practice under the Action Agenda on Nursing launched by the Department of Health in 1997.¹⁰⁰ They talked to practising and non-practising nurses about recruitment and retention. Proposed actions from the findings included developing more family-friendliness and flexibility with shift work by offering:

- the choice of day or night shifts;
- the choice to opt out of internal rotation;
- the choice to opt out of 12 hour shifts;
- the possibility of working peak hours (e.g. 8am to 12 noon, 5pm to 9pm);
- the possibility of working specified hours over a defined period to fit in with family commitments and school holidays;
- part-time and job-share work at all grades and which facilitates rather than inhibits career development;
- flexible childcare provision or vouchers.

On return to practice, the following practices were recommended:

- provide return to practice programmes with ENB recognition and academic credits;
- provide financial incentives to cover expenses whilst on the course, and pay when working in clinical areas;
- ensure high quality mentorship is available for duration of programme and for at least three months afterwards;
- provide a visible fast track programme which is competence based and enables returners to gain rapid promotion and achieve a post comparable with the level they achieved prior to leaving;
- introduce family friendly policies;
- ensure that returners are encouraged to pursue further studies and that support for this is provided;
- make sure a post is available at the end of the return to practice course and that hours and working patterns are negotiated and agreed to suit both the clinical area and the returner;
- advertise locally to seek local people who are committed to staying in the area;
- ensure that advertisements focus on the positive attributes which return to practice nurses have, such as previous experience and knowledge, the experience of caring for children or relatives, and other life experiences.

Sickness absence

In 1999, 60% of NHS trusts considered that their level of sickness absence was a problem and 86% were running or planned to run some form of initiative to reduce sickness absence.¹⁰¹

The average rate of sickness absence in the NHS is 4.6%. Even quite small percentage reductions in sickness absence can improve efficiency, reduce pressures on staff and obviate the need for using agency staff or even making permanent appointments. A 1% reduction in sickness absence in a trust employing 500 people is equivalent to gaining 5wte staff.

There is a significant body of evidence on methods for containing and reducing sickness absence. A recent series of six case studies by the Industrial Society across the public and private sector and including a local authority and NHS trust found several common success factors in minimising absence:¹⁰²

- senior management should be committed to the goal of reducing absence through performance management, good information systems and monitoring;
- personnel managers need to monitor absence rates and use this to ensure continued good practice;
- line managers should be fully trained to use the procedures;
- return-to-work interviews and informal procedures should be used to keep individuals well informed and resolve problems;
- employees should be treated with appropriate understanding, support and fairness throughout the operation of absence procedures.

Stress

Stress is difficult to define in medical terms, but the term seems to provide the best way of indicating a knot of work-related pressure and psychological distress. Research shows that the content and quality, and the effectiveness, of stress management interventions vary considerably. Researchers and practitioners are increasingly recognising the limitations of general, unfocused stress management initiatives and are proposing frameworks for interventions within organisations. Interventions designed to manage occupational stress need to target characteristics of the job and the organisation, in addition to the characteristics of the individual.

For example, attention to job design and job control (q.v.) can help to reduce role ambiguity and conflict. The introduction of lateral promotion (q.v.) schemes to supplement vertical ones avoids moving employees out of their areas of competence and compensates for lack of career progression (q.v.). Stress management needs to be seen as part of an overarching strategy to support staff through protecting and promoting their mental and physical health and well-being.

The provision of counselling services should form part of this strategy. The important point is that staff know that there is a confidential support service available, either within the organisation or paid for by the organisation. Some members of staff can be trained to be safe contacts with whom staff can discuss their operational concerns and workloads.

Support workers

The Sainsbury Centre for Mental Health looked at the role of support workers in community mental health services in *More than a Friend* (1997).¹⁰³ Lack of data has made it difficult for support workers to be included in the analysis of stocks and flows of the mental health workforce in the present review. However, it can be assumed that there is scope for taking some of the pressure off some mental health teams by exploring ways of increasing the contributions of support workers.

More than a Friend raised some important issues for consideration in this context. Support workers can make a unique contribution to community mental health teams, particularly regarding the provision of practical help with day-to-day housing needs, budgeting, daily living skills, and daytime activities. However, support workers do need close supervision and ongoing support. If they are to be involved in the provision of forms of help which require specific technical skills or knowledge, they also require training.

There was some concern in mental health services about the blurring of boundaries between support workers and professionally trained mental health staff, and the report emphasised issues of balance between the two sorts of staff, and considerations of skill mix.

Time for training and team development

The review did not aim to deal with training issues *per se*. Opportunities for training, however, form part of the system of rewards which can contribute to job satisfaction.

A recent study surveyed the skill development needs of five professional groups: psychiatrists, clinical psychologists, mental health nurses, social workers and occupational therapists.¹⁰⁴ All five professions identified their needs for training in:

- team functioning, including negotiation and conflict resolution techniques;
- needs, characteristics and principles of care for people who are dually diagnosed, homeless, or forensic patients;
- intensive case management;
- assertive outreach;
- cultural, race and gender issues in mental illness and mental health care;
- managing violence and aggression.

One of the main obstacles to providing post-qualification training and team development is the lack of time. When services are understaffed and experiencing severe pressure, taking the time for training and team development may seem a luxury. It is essential, however, that this time is protected. This issue is central in achieving effective clinical practice, and in sustaining morale

(q.v.) and preventing burnout (q.v.). Professional bodies should seek to address this key skill in basic training and in the initial selection of candidates for professional careers.

Users of mental health services

The assessment of performance across health and social care will be driven increasingly by the quality of experience of those who use the services. The negative impact of unsettled and understaffed mental health teams on service users provides a strong lever for securing improvements.

Volunteers

The review did not aim to cover volunteers *per se*. However, this is clearly an area where there is scope for expansion. Mental health is not one of the most popular areas for volunteering. In the context of current staff shortages, and in order to enrich the skills and experience available within mental health services, this is a good time to focus on developing the contribution of volunteers. The Sainsbury Centre for Mental Health publication *Is there anybody out there? A guide to recruiting volunteers in mental health* (1997) gives detailed information on successful strategies.¹⁰⁵

- Advertising – It is easier to recruit for a specific task than to carry out a general trawl for people who want to work in mental health: advertising should be as precise as possible.
- Positive publicity – The process of promoting the service to the public should go on all the time and may lead to volunteers coming forward to see if they can help.
- Targeting – Advertising and publicity campaigns can be targeted to match the age, gender, and ethnicity of volunteers with the client group.
- Motivation – It is important to consider what sort of people volunteer and why.
- Selection – Once a person responds to an advertisement, the follow-up should be swift and professional.
- Training and supervision – As for paid staff, opportunities for training and development are motivating to volunteers. In the field of mental health volunteering, it is essential that volunteers are properly supported in their work.

Work-life balance

Changing the work-life balance is now seen as a critical factor in improving not only the health and well-being of the workforce, but also the performance of organisations. The term “work-life balance” indicates that this debate has moved beyond “family friendly policies” to cover a wider range of needs and interests. The Department of Health has recently issued a resource pack: *The Improving Working Lives Toolkit* – see Resource Box 7.¹⁰⁶

Resource Box 7: The Improving Working Lives Toolkit

The *Improving Working Lives Toolkit* focuses on changing the work-life balance with particular emphasis on changing working patterns. It states:

“Effective healthcare delivery depends on having sufficient numbers of qualified well-motivated staff to look after patients, provide support services and fulfil key public health roles. Flexing working patterns to suit the changing circumstances of people’s lives is one important way of securing this workforce. This can be done through better retention of existing staff and improved recruitment to a service that is seen as sensitive to people’s needs.”

It provides information and examples and contacts for further information on:

- Team-based flexible rosters
- Annual hours
- Childcare support
- Reduced hours
- Flexi-time
- Carers
- Career breaks

Copies can be ordered by ringing 0541 555455

EXit interviews

In order to understand why employees are leaving:

- collect systematic information from those leaving or recently left through exit interviews or questionnaires;
- identify groups whose turnover is particularly high and assess associated costs.

This core information should be available to management to facilitate change in organisation and practice.

Young people

The numbers of younger people available to enter training for mental health work will increase over the next few years. This group needs to be targeted through positive publicity and liaison with schools. Much can be done to match some of the factors identified as most likely to attract young people into training with what is known about the rewards of mental health work.

Zero tolerance of violence against staff

In 1999 mental health / learning disability trusts reported a rate of 24 violent incidents per 1,000 staff per month.¹⁰⁷ Concerns about violent incidents, and about who will take responsibility for assessing risk, are major sources of stress and dissatisfaction for mental health staff. Resource Box 8 summarises recent guidance on developing a strategy to prevent and manage violence in mental health settings.

Resource Box 8: Managing the risk of violence

In 1988 the DHSS Advisory Committee on Violence to Staff recommended that there should be a local strategy that contained an assessment of problems of violence, preventative measures and suitable responses. There should be support for victims of violence, their colleagues, and other witnesses, so that people's sense of worth and value are safeguarded as much as their personal safety.¹⁰⁸

The Health and Safety Executive has produced guidance on the risk of violence to the mental health workforce,¹⁰⁹ and there is further guidance from the Royal College of Psychiatrists.¹¹⁰ These guidelines cover: ward design and organisation; anticipating and preventing violence; and medication in the context of violence. Implementation of these guidelines has potential to improve staff morale and the quality of the workplace generally as well as to reduce assaults on staff.

Within the NHS there is a high profile campaign to reduce violence faced by staff: the NHS Zero Tolerance campaign.¹¹¹ This recognises the concerns over levels of violence and requires trusts to develop local strategies to combat the problems. The Lord Chancellor has given a clear steer to magistrates that violence against care staff is not acceptable and does not "go with the job".

Local strategies are expected to include:

- risk assessment methods, carried out by appropriately trained staff;
- assessing the environment where staff work;
- training;
- communications to minimise risk to safety;
- effective reporting of all incidents;
- procedures for dealing with violent situations;
- post-incident management and support;
- local policies reflecting the above and detailing responsibilities;
- specific matters covering staff working in the community.

Good practice in managing the problem of violence at work

There are four main elements in organisational strategies which aim to prevent and manage violent incidents.

1 Minimising risk – Staff safety is paramount. All staff should aim to protect their own safety in the first place, and secondly, to protect the safety of colleagues and clients when faced with violence in the workplace. The organisation is responsible for risk assessment and the procedures used. There are four aspects of risk assessment for mental health services.

- 1 Risk assessment of the client, including a routine question regarding thoughts and feelings about violence.

- 2 Regular assessments of the working environment, both for hospital based staff and staff working in the community.
- 3 Additional assessments such as post-incident follow-up reviews.
- 4 Large scale assessments – risk assessment that examines all possible areas with safety implications, not limited to violence only.

Whilst risk assessments may follow a standard format, they must take account of individual and local circumstances and ensure that all relevant staff are briefed on possible dangers. Risk assessments for community based staff present additional challenges.

The organisation must be prepared to invest in environmental alterations, adapting premises, neutral colour schemes and putting in physical security, such as closed circuit TV, panic buttons, and personal alarms.

- 2 Training – The provision of appropriate training and regular refresher courses is essential. The organisation must have clear and agreed procedures for managing violence, and must ensure that all staff are trained to provide consistency and confidence. Training audits should be carried out to identify any gaps in the training that staff receive and trainers should be qualified and experienced in the relevant areas. Training should include calming / de-escalation techniques, breakaway techniques, and control and restraint techniques.

The UKCC, in partnership with other stakeholders, is currently developing national standards in the management of violence and use of physical interventions.¹¹²

- 3 Reporting incidents – It is vital that all incidents (including so-called near misses) are reported. This should allow organisations to learn from the experience, and to detect and address any relevant patterns. Reporting should cover immediate reporting, more detailed reporting shortly after the incident, and formal post-incident reports.

Staff should be trained in reporting incidents, understanding the reasons for reporting, the methods for reporting, and guidance on the types of incidents to be reported.

- 4 Employee support – This should include immediate debriefing, both for the individual and the team. Post-traumatic stress counselling should be offered. Personal counselling should also be provided, and should cover the immediate effects, anxiety and reactions, medium term effects, rebuilding confidence, and possible longer-term effects such as post-traumatic stress.

Peer support schemes can be helpful for staff, and can be provided through either informal or formal support groups. Special arrangements should be made for the individual's recuperation, recognising trauma, anxiety and loss of confidence, and easing their return to work.

Finally, the organisation should publicly state support for employees and make clear that legal action may be taken against those who threaten or use violence against staff.

Introduction

This report has so far described the global picture in terms of staff shortages within the mental health workforce, the range of other factors which affect recruitment and retention, and the possible solutions. This picture will however, vary from authority to authority and from employer to employer, and there will be local complexities which require local approaches. This chapter attempts briefly to describe the steps which local employers – NHS trusts, social services departments and health authorities – can take to formulate their own local strategies on recruitment and retention.

As with all planning cycles, there are four basic phases of action to be delivered:

- diagnosis and assessment of any current or likely future staffing shortages;
- formulation of the solutions;
- implementation;
- evaluation and review of the strategy.

1 Are there current or likely future shortages?

This may seem an obvious question, which can easily be answered locally. For example, in a NHS trust the chief executive and directors will have a clear idea as to which, if any, staff groups pose difficulties. However, more detailed analysis is required if the exact picture – and the reasons for it – are to emerge. Some or all of the following steps may be required to assess whether and why problems exist:

- 1 collection of information on vacancies, turnover and use of agency staff over time, within each staff group;
- 2 assembly of information on the trends in the local labour market from local business organisations, demographic trends etc;
- 3 informal and formal discussion with senior and junior staff;

- 4 discussion with any relevant educational establishments which have links with the organisation;
- 5 exit interviews, or if this is not feasible, at least exit questionnaires;
- 6 results of recent recruitment campaigns including response rates, shortlisting rates and appointment rates;
- 7 equal opportunities monitoring data;
- 8 reference to, and possibly further analysis of, the business plan to determine how staffing patterns will need to change over time.

In some cases, external consultancy might be helpful to deliver some of these steps. Even organisations which do not perceive that they have a current problem would be well advised to carry out this analysis to uncover hidden problems and assess likely future risks. This analysis will also allow them to test the robustness of the HR section of their business plan.

Once some or all of this information is brought together, and set alongside national data (see Appendix 4), it should be possible to produce an analysis of what, if any, problems exist, and why. This can be broken down by:

- staff group;
- other staff characteristics such as ethnicity, gender and age;
- the nature of the problem (is it mainly recruitment or retention? where precisely does it arise in the cycle?);
- the reasons for the problem (e.g. low morale, low application rates due to unattractive working environment, violence);
- the likely relationship with the overall labour market (i.e. is national supply increasing or decreasing, is local supply increasing or decreasing?);
- quality issues;
- cover for vacant posts.

This analysis should be locally tuned and determined and should not exclude the “gut instincts” of senior managers – but it should seek also to gather as much hard information as possible. The analysis should result in a few clear headline conclusions which can be communicated to the board or authority and which will drive solutions and implementation. However, if the problem is too complex to state in this way it is important not to over-simplify. This will vary from area to area.

2 Solutions to the problem

The analysis of the problem should lead fairly naturally to the chosen package of solutions. This report lists many of the possible sorts of solutions that have been used to tackle recruitment and retention issues over the years. Most represent good management practice which employers will want to achieve anyway. However, the more targeted solutions must be matched to local circumstances. For example:

- if violent incidents are increasing and causing significant staff concern, strategies to manage violence and to deal with incidents afterwards may be a priority;
- strategies to retain older staff may be key if local demography indicates this and if many older staff are leaving in their mid fifties;
- if sickness absence is high this may be an indicator of other problems but may also be an area for significant efficiency gains using the current workforce;
- if there is a significant pool of qualified women with children in the area, family friendly policies may be a key priority.

In most cases the links between the analysis and targeted solutions should be obvious. Solutions should be assessed on a number of criteria:

- using the national and local evidence, what is the impact of the measure likely to be in terms of recruitment and/or retention?
- what is the likely impact on staff morale?
- what is the likely impact on equal opportunities and other elements of good management practice?
- what are the crude costs, and the costs per member of staff recruited and retained per year?
- what is the required time investment by management?
- how many staff will benefit and in which groups?
- are there alternative solutions which are more cost effective, better targeted or more widely beneficial?
- how does the solution fit within the organisational ethos and HR strategy?
- will there be gains in terms of skills and efficiencies as well as numbers of staff?
- how do the solutions fit with the organisation's broader aims and strategies, especially specific service development plans?
- what is the impact in training terms and the relevance to training plans?
- is a change in skill mix more appropriate?

3 Implementation of the solutions

The solutions suggested in this report are diverse and will require many different implementation cycles, depending also on local circumstances. As well as the usual basic principles of establishing clear leads and timescales and identifying resources – which are often overlooked – a few other general principles may be of help:

- 1 Involve stakeholders especially unions, staff associations, professional bodies, and staff themselves, via meetings and surveys. In some cases it may be appropriate to engage carers, users, and other employers, especially partner agencies. Local business support agencies such as Chambers of Commerce may be helpful for information and support.
- 2 Communicate the strategy as part of an overall package of measures. Underline the benefits for staff and patients. Single shot or scattergun approaches are not only often ineffective, but they also do not create a convincing package for staff.
- 3 Secure the support of boards / authorities and commissioners.
- 4 Ensure that the resource arguments are right. Consider contingencies – e.g. recruiting a bigger field of nurses than expected or reductions in the available resources.
- 5 HR departments will sometimes be in the lead, but where, say, a clinical director is leading, the role and support of the HR director will need to be clear.
- 6 Link recruitment and retention to the wider business planning of the board / authority – for example to service development or the estates strategy.
- 7 Engage non-executives or elected representatives with interest or expertise.
- 8 Ensure that regular reports are issued to the relevant board / authority or sub-committee and engage the Chair's interest.
- 9 Report on successes using a variety of communications mechanisms, including the house journal.
- 10 Make explicit links to the business planning cycle.

4 Evaluation of the strategy

Timely evaluation is key to building on success in this area, where some labour market changes will be relatively fast moving. The success of programmes or part programmes should be continuously evaluated using the sort of data set described above. Graphical representation of the key data over time is a good way of judging the impact of specific initiatives. Reports to the board / authority should always include an evaluative element and any resulting changes equally require evaluation.

For more ambitious programmes a more robust model of evaluation may be useful. There is a variety of evaluative expertise in most boards / authorities with a mental health interest. It may be worth approaching the R&D committee chair, clinical directors and chief psychologists in particular, if a firmer piece of evaluation is required. In some cases external providers of personnel or recruitment services can be asked to undertake their own evaluation to set benchmarks as part of the contract. In other cases partner universities might be interested in evaluating activities. Dissemination via journals or good practice web-sites may also be relevant and valuable.

1 The core conclusions

The review reached three core conclusions.

1 There are shortages of appropriately skilled staff

There are current and potential difficulties in the supply of staff in terms of both quantity (the numbers of staff available) and quality (the skills and competencies of staff).

2 Practical steps can be taken

There are practical and evidence-based steps which can be taken to tackle recruitment and retention difficulties. The Government has now provided a helpful policy and financial context. Much can also be done to unlock energy and commitment from existing staff.

3 A whole systems approach is needed

Problems with recruitment and retention need to be approached within a whole systems context which has the overall aim of strengthening the structures of good employment and good management practice. The strategy as a whole will only be as strong as its weakest link. We have identified three strategic priorities:

- Attract and retain: make HR strategy central to the organisation;
- Lead and inspire: strengthen leadership;
- Support and sustain: make mental health promotion a priority in the HR strategy.

Locally, managers will need to consider what status to give these priorities, and to the more specific solutions described in this report, in the light of local information and needs. A process for achieving this was outlined in the previous chapter.

2 The recommendations

1 Employers need to set up adequate management information systems to measure or evaluate:

- vacancy levels and turnover in each staff group;
- use of locums, agency staff and other forms of cover;
- staff absence rates;
- effectiveness of recruitment measures;
- reasons for staff leaving.

Regular reports need to be made on these issues to the relevant Board/Authority.

ACTION: HR Directors, Boards/Authorities

2 The Department of Health needs to harvest the information collected under Recommendation 1 to inform national planning and policy development. This information should be in the public domain. This should be included in the mental health information strategy.

The Department of Health should commission a specific research study of numbers and trends in mental health social work. The study should make recommendations on the national minimum data set required on mental health social work.

ACTION: Department of Health.

3 Employers who decide that they have significant problems in relation to recruitment and retention need to develop clear local strategies and action plans for addressing them, with reference to the possible solutions described in this report.

ACTION: HR Directors, Chief Executives/Directors, Boards/Authorities

4 This review strongly supports the proposals on workforce planning contained in the Department of Health consultation document *A Health Service of all the talents*. If implemented across the NHS as a whole these proposals will be of significant benefit to mental health services.

ACTION: Department of Health

-
- 5 Employers should consider what steps should be taken to make full use of the mature workforce (i.e. those aged 50-70).

ACTION: HR Directors, Boards/Authorities

-
- 6 The Department of Health should review the current pensions arrangements to determine what impact they have on the retention of mature staff. The Department of Health should develop options for reform which will encourage mature staff who are willing and able to do so, to stay on after their retirement dates, possibly in part-time work or in different work roles.

ACTION: Department of Health

-
- 7 All major employers in the sector require sufficient numbers of professionally qualified HR staff. All senior HR staff working in mental health should either be professionally qualified or should be enrolled in a recognised and accredited course leading to a professional qualification.

ACTION: Chief Executives/Directors, Boards/Authorities, Department of Health

-
- 8 Adequate time must be set aside for Continuing Professional Development. Each employer should implement Personal Development Plans and Training Strategies to support this.

ACTION: HR Directors, Managers and Clinical Supervisors

-
- 9 Personal Development Plans and Training Strategies should address management and leadership development where this is appropriate for individual staff or staff groups.

ACTION: HR Directors, Managers and Clinical Supervisors

-
- 10 Managers and Clinical Supervisors of professional staff should actively manage workloads to maximise the amount of patient contact. Workload and time management should be built into training strategies and course development.

ACTION: Managers, Clinical Supervisors, HR Directors

-
- 11 Each employer should appoint a lead Director/Deputy Director to take responsibility for the simplification and integration of procedures such as care planning, record keeping etc. This person should report at least annually to the Board/Authority on progress in simplification and plans for future simplification.

ACTION: Chief Executives/Directors, Boards/Authorities

-
- 12 Each employer should develop a mental health promotion strategy for its workforce. Strategies should be evaluated and reviewed annually.

ACTION: HR Directors, Chief Executives/Directors, Boards/Authorities

Chair:

Sir Graham Hart KCB, Chair, The King's Fund and former Permanent Secretary, Department of Health

Members:

Geoff Bourne, English National Board for Nursing, Midwifery and Health Visiting

Richard Bradshaw, Professional Officer for Mental Health and Learning Disabilities, UK Central Council for Nursing, Midwifery and Health Visiting

Judith Croton, Central Council for Education and Training in Social Work

Peter Hobbs, Chairman, Learning from Experience Trust. Formerly Her Majesty's Inspector of Constabulary, Director of Wellcome plc and Vice-President of the Institute of Personnel Development

David Joannides, Chair, Association of Directors of Social Services and Director, Dorset Social Services

Dr Robert Kendell, formerly President, Royal College of Psychiatrists and Chief Medical Officer for Scotland

Dr Andrew McCulloch, Senior Adviser, The Sainsbury Centre for Mental Health

Dr Matt Muijen, Director, The Sainsbury Centre for Mental Health

Malcolm Philip, HR Consultant, The Sainsbury Centre for Mental Health and Director of Personnel, The Maudsley Hospital

Paul Thain, Director of Human Resources, Norfolk Mental Health Care NHS Trust

Lynne Woodward, Project Manager (Mental Health), Healthcare NTO (February – September 1999)

Richard Berry, Mental Health Branch, NHS Executive, Department of Health (Observer)

Journals used: *Health Service Journal, Community Care*, 17 February 1999

“ Call for evidence: Review of the Mental Health Workforce

The Sainsbury Centre for Mental Health is carrying out a review of the mental health workforce with the following terms of reference:

- *To examine the current and future supply of mental health staff, and identify factors affecting their recruitment and retention;*
- *To assess the need for action to address the identified difficulties;*
- *To make recommendations on the specific steps required to secure an adequate supply of mental health staff to meet future needs.*

The review commenced in February and will be completed by early 2000. It is overseen by a steering group comprising members from key professions or management backgrounds, and chaired by Sir Graham Hart. The review is focused on the main staff groups which commission and provide mental health services (including social care for mentally ill people) in the public and independent sectors. The strategic focus is to assess future supply problems and to generate creative solutions.

If you are commissioning or providing mental health services and are facing or have overcome staff supply problems we would be very pleased to hear from you. We would be particularly interested in

- hard information on existing or expected future supply problems;
- successful (and unsuccessful) approaches to solving supply problems, highlighting the learning points.

Please contact Heather Harper, Researcher, at The Sainsbury Centre for Mental Health, 134–138 Borough High Street, LONDON SE1 1LB, tel 0171 403 8790 or fax 0171 403 9482.”

LIST OF ORGANISATIONS THAT
RESPONDED TO THE CALL FOR EVIDENCE

Organisations

The Association of Counsellors and
Psychotherapists in Primary Care, Ltd
British Medical Association
British Medical Association, Scotland
Burnley General Hospital
Chartered Society for Psychotherapists/
Physiotherapists
Counselling in Primary Care Trust
Department of Health
Dorset Healthcare NHS Trust
East Kent Community NHS Trust
Edinburgh Healthcare NHS Trust
Enfield Community Care NHS Trust
Family Welfare Association
The Foundation NHS Trust
Hull and Holderness
Inner Cities Initiative Group
The King's Fund
Leicestershire Mental Health Service NHS Trust
MENCAP
Newcastle City Health NHS Trust
NHS Executive
Northern Devon Healthcare
North Staffordshire Combined Healthcare NHS
Trust

Northern Ireland Junior Doctors Committee
Nottingham Healthcare NHS Trust
Oxleas NHS Trust
Portsmouth Healthcare NHS Trust
Royal College of General Practitioners
Royal College of Psychiatrists & Independent
Healthcare Association Liaison Group
Scunthorpe Community Health Care NHS Trust
Sevenoaks and District Mental Health Services
South Birmingham Mental Health NHS Trust
Southside Partnership
Thameside Community Healthcare NHS Trust
UNISON
Wakefield and Pontefract Community Health
Trust
Wimbledon Community Care Partnership

Individuals

Linda Christian
Gerarde Dawe
Miss A Hamit
Nick Purchase
Mr Spencer
Moirra Watson
James Wilson
Sheila Wright

1 Psychiatrists

There are relatively good data on the numbers and availability of psychiatrists in England. The broad picture is as follows:

- numbers of consultant psychiatrists are low relative to international comparators and to perceived demand. The Government has recently announced an increase in the training places available in psychiatry with the intention of providing an extra 1,500 mental health specialists by 2006/7;¹
- in 1999, 36% of trusts employing consultant psychiatrists reported recruitment difficulties and 5% reported retention difficulties – both these were the highest levels for any specialty.²

Full data are available on current vacancy rates in psychiatry and these are summarised in Table 1.

Table 1: Total consultant psychiatrist posts (full time and part time including vacancies) and vacancies (including posts filled by locums) in England in 1995 and 1998

| Specialism | 1995 unfilled posts | 1998 unfilled posts | 1995 total posts | 1998 total posts | % change 1995-98 (unfilled posts) | % change 1995-98 (total posts) |
|------------------|---------------------------|---------------------------|------------------------|------------------------|---|--------------------------------------|
| General adult | 145 | 199 | 1222 | 1368 | +37.2% | +11.9% |
| Psychotherapy | 14 | 8 | 139 | 126 | -42.9% | -9.4% |
| Substance misuse | 8 | 13 | 65 | 80 | +62.5% | +23.1% |
| Rehab. | 9 | 14 | 58 | 55 | +55.6% | -5.5% |
| Liaison | 3 | 1 | 10 | 23 | -66.6% | +130% |
| Forensic | 17 | 23 | 128 | 153 | +35.3% | +19.5% |
| TOTAL | 196 | 258 | 1622 | 1805 | +31.6% | +11.3% |

Source: Royal College of Psychiatrists Annual Censi

NOTE: All figures in this Appendix are for England unless stated

As many locums are inadequately trained and cannot provide long term continuity, these figures give evidence of major problems across all subspecialties. The only exception is forensic psychiatry which has few problems except in the three special hospitals.

Psychiatry is also unique in that there are figures for the ethnic composition of the profession. In 1997 71% of consultant psychiatrists were white, 3% black, 11% Asian and 14% were from other groups or of unknown ethnic status.³ The same percentages for all medical staff in the psychiatry group were 65%, 5%, 14% and 16% respectively. There is therefore evidence of under-representation of black people in the consultant grade, but adequate representation of some other ethnic groups.

Current stocks

Numbers of consultant psychiatrists have been rising slowly for a number of years.

Table 1 shows modest growth, insufficient to meet demand given vacancy levels and the demands of policy. This growth has been matched by a greater percentage growth in unfilled posts.

Future projections

The Department of Health (DoH), prior to the April announcement on increased medical training places, has carried out projections of future stocks of psychiatrists. These are presented in Table 2.

Table 2: Future projections: consultant psychiatrists

| Specialty | 1999 (actual) | 2000 | 2001 | 2002 | 2003 | 2004 |
|------------------|------------------|------|------|------|------|------|
| General Psychia. | 1493 | 1498 | 1508 | 1743 | 1868 | 1868 |
| Child & Adol. | 489 | 510 | 526 | 654 | 679 | 679 |
| Forensic | 164 | 166 | 186 | 241 | 238 | 238 |
| Rehab. | 64 | 66 | 74 | 76 | 139 | 143 |
| Old Age | 276 | 288 | 309 | 318 | 389 | 488 |
| Psychotherapy | 119 | 123 | 133 | 163 | 166 | 166 |
| TOTAL | 2605 | 2651 | 2736 | 3195 | 3479 | 3582 |

Source: Unpublished DoH projections, used with permission

Once the new training places which have been announced have impact on these figures, which they should do in 2004/5, the rate of growth will increase – by around 230 consultants per year for as long as the increased growth is sustained. We can therefore expect the number of consultant psychiatrists to exceed 4000 in 2006 on current information. Whilst these figures are encouraging, the slower rate of growth in general adult psychiatry – the group of professionals which has to deliver the majority of front-line services – is of some concern.

Overall picture

It seems likely that the next five years will see substantial growth in the number of consultant psychiatrists, but this is unlikely to solve all problems of recruitment and retention. New psychiatrists may be attracted to favoured areas and subspecialties, leaving mainstream services under-supplied, especially in inner city areas. Particular attention to recruitment and retention in these areas will be required for some years.

16% of consultant psychiatrists currently work part time and this is expected to remain at a similar level.⁴ Increases in part time working might assist retention but also lead to drops in the efficiency of the deployment of the total stock.

For the last five years the highest numbers of consultant vacancies have consistently been in North West England, North East Thames and Trent.⁵

2 Mental health nurses

While the problems of recruiting mental health nurses are widely publicised, hard data on the extent of vacancies are limited. The DoH *Recruitment, retention and vacancies survey (1999)* indicated that 2.1% of all nursing posts in psychiatry were considered hard to fill. 85% of 100 trusts surveyed by the NHS Executive reported difficulties both in recruiting and retaining nursing staff generally, commonly in D and E grades and particularly in mental health.⁶ The site visits for this review confirmed that NHS trusts are having difficulties with nursing vacancies, and that some are making heavy use of agency nurses.

Current stocks

Information on the numbers of qualified nurses working in NHS mental health services are available from the DoH non-medical workforce census, but they include child and elderly services.⁷ The 1998 headcount figure was 37,261 (33,775 wte) of which 65% were female. This represented a 2.6% decrease on the previous year. 23.6% of these nurses were aged 45-54 and 5.3% were aged 55-64.

An alternative source of data is the UK Central Council (UKCC) register.⁸ This covers all sectors, not just the NHS. It gives a total headcount of registered/enrolled mental health nurses of 55,500 for 1999. The UKCC figure for mental health nurses in the NHS is 38,856 for 1999.

The most recent, unpublished, DoH figures for the number of mental health nurses is 35,207 (wte). These figures are all broadly consistent.

Future projections

There are some pointers which can be used to support projections as to the future availability of nurses. UKCC data show that the number of active registrations of nurses as a whole (working in all sectors) increased by 4.5% between 1990 and 1999. However, over this period the number of newly qualified registrations decreased and the number of nurses leaving the register is considerably higher.

The ENB provides annual data on the numbers of newly qualified nurses with a mental health specialism, broken down by gender.⁹ These figures are shown in Table 3.

Table 3: Newly qualified nurses with mental health specialism (per year)

| Year | Headcount | % Male | % Female |
|--------|-----------|--------|----------|
| 1998/9 | 2144 | 29 | 72 |
| 1997/8 | 2015 | 28 | 72 |
| 1996/7 | 2389 | 30 | 70 |
| 1995/6 | 2632 | 34 | 66 |
| 1994/5 | 2874 | 34 | 66 |

Source: ENB Annual Reports

There appears to be a significant decline in the number of nurses with a mental health specialism who are becoming eligible for registration, albeit with a slight upturn in 1998/9. The number of men qualifying is dropping.

Various projections for future numbers of qualified (and unqualified) mental health nurses have been produced by the DoH.¹⁰ The most recent, unpublished, projections are the most optimistic, but all show significant growth of qualified nurses in the medium term in the range 12-16% over the period 1999/0 to 2004/5. Table 4 shows a recent set of unpublished projections prepared by the Department of Health. These projections give some cause for optimism over the supply of mental health nurses in the medium term.

Table 4: Projected growth in psychiatric nurses

| | 1999/0 | 2000/1 | 2001/2 | 2002/3 | 2003/4 | 2004/5 | % gro'h |
|-----------------------|--------|--------|--------|--------|--------|--------|---------|
| Qualified hospital | 25449 | 25951 | 26600 | 27473 | 28542 | 29479 | 15.8 |
| Qualified community | 9758 | 10051 | 10353 | 10664 | 10984 | 11314 | 15.9 |
| TOTAL qualified | 35207 | 36002 | 36953 | 38137 | 39526 | 40793 | 15.9 |
| Unqualified hospital | 15234 | 15535 | 15923 | 16445 | 17086 | 17646 | 15.8 |
| Unqualified community | 1926 | 1984 | 2043 | 2105 | 2168 | 2233 | 15.9 |
| TOTAL unqualified | 17160 | 17519 | 17966 | 18550 | 19254 | 19880 | 15.8 |

Source: Unpublished DoH projections, used with permission

3 Social workers

Data on social workers working in the mental health field are poor. They are probably more fragmented than they are for any other staff group. However, there are some clear pointers of possible shortfalls. Table 5 shows significant levels of vacancies and rapid turnover in the residential sector. However, it is not known how many of the staff in these posts are social workers.

Table 5: Vacancy rate and turnover rates for staff of homes for adults with mental health problems (as a % of the total posts). 1997. England

| | Vacancy rate % | Vacancy rate % | Turnover rate % | Turnover rate % |
|---------------------------|----------------|----------------|-----------------|-----------------|
| | Full time | Part time | Full time | Part time |
| Officers in charge | 7.9 | 0.0 | 16.8 | 0.0 |
| Deputy officers in charge | 13.2 | 0.0 | 12.1 | 0.0 |
| Other supervisory staff | 13.7 | 22.1 | 17.5 | 10.0 |
| Care staff | 11.5 | 11.1 | 12.0 | 24.0 |

Source: Social Services Workforce Survey (LGMB/ADSS)

There is no hard evidence on shortfalls of social workers in community settings, but there is considerable anecdotal evidence that they are not always easy to recruit.

Current stocks

Again, data are poor, due to differing definitions over time. It is also unclear on some occasions whether staff are qualified or not. Table 6 contains the best available data but they have low credibility. These data include managers as well as front-line social workers. An unpublished Sainsbury Centre estimate of the number of social workers in CMHTs is 4,500.

Table 6: Social services employed social workers working in adult mental health. 1996. England

| | Headcount |
|-------------------------------|-----------|
| Day care centres | 1949 |
| Residential homes and hostels | 2049 |
| Non-establishment based | 536 |
| TOTAL | 4534 |

Source: Social Services Workforce Survey (LGMB/ADSS)

Future projections

These are hard to develop based on the limited and poor quality data available. The DoH calculates that there will be a growth rate of social work within mental health of around 1% per annum, but based on very small stock figures which are not credible. Growth as low as 1% would severely restrict the development of the social care function in mental health. The first step in diagnosing the problem and redressing the balance might be to commission a study of the numbers and growth rates of social workers in mental health.

4 Clinical psychologists

There is a significant shortfall in the numbers of clinical psychologists which is well recognised and which was reflected in the site visits for this review.^{12,13} However, this is not well quantified.

Current stocks

The total stocks of clinical psychologists can be estimated from the DoH workforce survey and from British Psychological Society membership numbers. However, there is no breakdown of the numbers of clinical psychologists working in adult mental health. The DoH non-medical workforce census gave a total stock of 4,162 wte clinical psychologists in 1998 (4,918 headcount) including all grades and trainees.¹⁴ The membership of the clinical psychology division of the BPS in the same year was 3,331 which represents between 75% and 85% of practising clinical psychologists.¹⁵ An

unpublished DoH figure for the current stock (wte) is 3,706. If this latter figure is assumed to exclude trainees, the figures are all broadly consistent.

Future projections

All the indications are that there will be steady but unspectacular growth in the supply of clinical psychologists over the next few years. Table 7 shows the numbers of students entering clinical psychology training by year and by source. Almost all students must enter this training via the Leeds University clearing house so this provides a clear indication of the likely growth rate of newly trained clinical psychologists.

Table 7: Numbers entering clinical psychology training by year and source (GB)

| Source | 1996/7 | 1997/8 | 1998/9 | 1999/0 | 2000/1 |
|----------------------------|--------|--------|--------|--------|--------|
| Training commissions (DoH) | 258 | 281 | 312 | 341 | 396 |
| Clearing | 289 | 314 | 347 | 377 | - |

Source: Clinical psychology clearing house

The latest, unpublished, DoH projections for the growth in clinical psychologists are shown in Table 8. It is not possible to state whether this rate of increase is sufficient to meet current or future demand, but it will clearly be of significant benefit to trusts with current shortfalls.

Table 8: Projections for the numbers of clinical psychologists (wte)

| | stock 1999/0 | % increase 2000/1 | % increase 2001/2 | % increase 2002/3 | % increase 2003/4 | % increase 2004/5 | stock 2004/5 |
|------------------------|-----------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-----------------|
| Clinical psychologists | 3,706 | 2.0 | 2.2 | 2.6 | 3.5 | 3.2 | 4,229 |

Source: Unpublished DoH projections, used with permission

5 Occupational therapists

There are relatively good data available on the numbers and flows of occupational therapists (OTs), but these data relate to the profession as a whole and not specifically to OTs employed in mental health. However, reasonable estimates of the numbers in mental health can be made. The broad picture is described below:

- There are between 3,851 and 4,280 OTs working in mental health.
- The vacancy and turnover levels for all OTs in the NHS is high.

- However, there is an upward trend in the number of OTs – giving some optimism that supply may improve in the future both for mental health and other sectors.

Table 9 gives the current vacancy and turnover rate for all OTs. There is evidence of rapid movement and unmet demand. It is hard to judge to what extent these rates apply specifically to mental health services. Evidence from site visits and local management experience suggest that mental health services do experience turnover and vacancy rates which reflect the broader picture. Recent data from DoH contradict this position, suggesting an average three month vacancy level of only 1.9% for OTs in mental health services in England.¹⁶ This figure must be questioned on the other evidence available to this review.

Table 9: Vacancy and turnover rates for all occupational therapists as a % of total posts.

| | Vacancy rate % | Turnover rate % |
|-----------|----------------|-----------------|
| Full time | 10.2 | 15.1 |
| Part time | 8.3 | 12.2 |

Source: LGMB/ADSS 1997

Current stocks

The 1998 DoH non-medical workforce census identified 14,266 OTs working in the NHS as a whole. In the same year there were 18,502 OTs registered with the Council for Professions Supplementary to Medicine.¹⁷ Table 10 shows how these staff broke down into the three main groups of therapist, assistant and instructor. It should be noted that the OT workforce is overwhelmingly female except in the instructor/teacher category.

Table 10: Occupational therapists in the NHS, 1998

| | Headcount | wte | Male % | Female % |
|------------|-----------|--------|--------|----------|
| Therapist | 9,187 | 7,794 | 6 | 94 |
| Assistant | 2,505 | 1,881 | 10 | 90 |
| Instructor | 2,568 | 2,198 | 32 | 68 |
| TOTAL | 14,266 | 11,873 | | |

Source: DoH non-medical workforce census 1998

There are currently two estimates of the proportion of OTs working in mental health. The College of Ripon and York study found this to be 27%,¹⁸ and the British Association of Occupational Therapists 30%.¹⁹ Using the DoH figure of 14,266 OTs working in the NHS in 1998, this gives a range of 3,851-4,280 OTs working in mental health.

The Ripon and York study also examined other areas such as retention and experience. It estimates that 40% of those working in mental health had done so for 2 years or less and only 10% had worked for 11 years or more. This raises concerns about quality if managers promote staff rapidly to improve retention – perhaps before they are sufficiently experienced to take on senior roles.

Future projections

Applications to OT courses show a considerable decline of about 46% over the last five years. There were 16,544 applications in 1995 as opposed to 8,915 in 1999. The current ratio of male applicants to female is 1:11.²⁰

However, DoH projections for the future numbers of OTs are reasonably optimistic. These are set out in Table 11.

Table 11: Projections of occupational therapists in the NHS (therapists only).

| Year | Projected population | Number in MH (assuming 27%) | Number in MH (assuming 30%) |
|---------|----------------------|--------------------------------|--------------------------------|
| 1998/9 | 8,888 | 2,400 | 2,666 |
| 1999/0 | 9,239 | 2,495 | 2,772 |
| 2000/01 | 9,892 | 2,671 | 2,968 |
| 2001/02 | 10,235 | 2,763 | 3,071 |
| 2002/03 | 10,482 | 2,830 | 3,145 |
| 2003/04 | 10,757 | 2,904 | 3,227 |

Source: DoH, used with permission

The overall picture of gradually increasing supply is therefore helpful, but locally and nationally, attention should be paid to:

- the apparent decline in the level of interest in OT as a career choice;
- the low levels of interest shown by men;
- the need to develop a more experienced workforce.

NOTE: Much of these data are analysed in further detail in the Institute of Employment studies report: Bevan, S., Regan, J., Harper, H. and Rick, J. (2000) op. cit.

THE EFFECT OF EMPLOYEE PERCEPTION ON ORGANISATIONAL PERFORMANCE

There is now good evidence that how employees feel about their work, and how they are managed, make a significant difference to organisational outcomes and costs.^{21,22,23,24} Some of this research from other sectors of the employment market is relevant to the present review. In particular, the research asserts direct links between:

- the quality of employees' experience of the organisation in which they work;
- the quality of the performance of that organisation;
- the quality of experience of those who use the organisation.

Links between employees' job satisfaction and commitment to an organisation, and the performance of the employees and the organisation

The impact on performance of employees' attitudes to their jobs, and commitment to their organisation, has been studied extensively and over many years. Most studies have examined whether, and to what extent, an individual employee's satisfaction with their job and commitment to their organisation affects their individual work performance (i.e. the question is, "if I am more satisfied with my job and more committed to my organisation, will I perform better?"). The results have been fairly conclusive; there is a small but statistically significant positive association between individuals' job satisfaction, organisational commitment and work performance.²⁵

However, there has been little research into how the attitudes of groups of employees affect the whole organisation's performance. In the UK, only one study has addressed this question: the Sheffield Effectiveness Programme.²⁶ Private sector manufacturing organisations were the focus. The main results are summarised below.

- 1 Employees' attitudes to job satisfaction and their commitment to the organisation together accounted for a total of 23% of the variation between companies' changes in productivity. Separately, job satisfaction explained 16% of the variation between companies and organisational commitment explained an additional 7% of that variation.
- 2 Employees' attitudes to job satisfaction and their commitment to the organisation together accounted for a total of 10% of the variation between companies' changes in profitability. Job satisfaction explained 5% of the variation between companies and organisational commitment explained an additional 5% of that variation.

In *The Human Equation* (1998) Pfeffer reviewed US studies of the same employee attitudes-organisational performance relationship but conducted in a different organisational setting: for-profit organisations that provided face-to-face customer services (e.g. banks). Some of the key findings from studies involving different organisations from different service industries are set out below.

- 1 The more positive employees' attitudes, the more positively the customer felt about the quality of the service and the more satisfied they were with the service they received. These attitudes were linked with better profits.²⁷
- 2 Employees' attitudes to their workload, teamworking, training and development, and satisfaction with their jobs, were all positively associated with customers' satisfaction.²⁸
- 3 Employees' attitudes to the fairness of their pay, management's concern with their welfare and fair treatment of the workforce, and to openness and the quality of the working environment were positively and significantly related to customers' perceptions of the quality of the service they received.²⁹

Links between employees' commitment and organisational performance

Employee commitment is based on employees having a sense of ownership, loyalty and pride in their work. Barber, Hayday and Bevan (1999) conducted a pathway analysis of data relating to employees' and customers' attitudes and behaviour and organisational performance.³⁰ They found that employee commitment directly affected change in organisational performance. Employee commitment was driven by organisational culture (i.e. what the organisation is seen to value, and support and promote) and by employees' satisfaction with their line management.

Employee commitment also affected change in organisational performance indirectly, as indicated below.

- 1 Positive commitment from employees relates directly and positively to customers' satisfaction with the services they receive, i.e. the more committed the employee, the more satisfied the customers.
- 2 Negative commitment from employees relates directly to their absence and directly and negatively to customers' satisfaction with the services they receive, i.e. the less committed and more absent the employees, the less satisfied the customers.
- 3 Customers' satisfaction affects their intentions to return to and use the service, and the realisation of these intentions in their behaviour results in changes in the organisation's performance.

Links between organisational culture and performance

To what extent does an organisation's culture influence its performance? While organisational researchers and developers are increasingly interested in this area, few studies have examined the

impacts and outcomes of cultural factors. The Sheffield Effectiveness Programme³¹ from the Institute of Work Psychology is, again, probably the most informative and its findings are summarised below.

Do cultural factors predict changes in organisations' productivity and profitability over a three or four year period? If a meaningful relationship between organisational culture and organisational performance is defined by *statistical significance*, then cultural factors do not account for changes in organisational profitability but do account, somewhat, for changes in organisational productivity. Patterson *et al.* found that (a) employees' having feedback on their job performance and (b) feeling that they were valued and trusted, were significant positive predictors of change in organisations' productivity.

If a meaningful relationship between organisational culture and organisational performance is defined by the *amount of variation between companies in change in their productivity explained by the culture variables*, then a similar pattern is seen. Cultural factors explained some of the differences in how profitable organisations were and considerably more of the differences in how productive organisations were. Human relations *alone* (i.e. the sense of being valued, autonomous, trained and supported) explained 29% of the variation between companies in the changes in their productivity over the subsequent three or four year period.

These findings point to the conclusion that cultural factors are important in predicting organisational performance.

Which cultural factors are the more important predictors of between-organisation changes in productivity and profitability over a three or four year period? Human relations (employees' sense of being valued, autonomous, trained and supported) was the *only* statistically significant predictor of variation between organisations in changes in both their productivity and their profitability. This finding should not be under-estimated: the most stringent test of the relationship between cultural factors and outcomes (i.e. statistical significance) was applied and this predictive relationship was still detected after a considerable period of time.

In brief, there is good evidence to indicate that employees' feelings do affect organisational performance. The more satisfied employees are with their jobs and the more committed they are to the organisation, the better the organisation is likely to perform, in terms of its subsequent productivity and profitability. Further, this is the case in both product- and service- oriented organisations; and, indeed, is possibly more the case when the primary focus is on providing a face-to-face service.

To the exclusion of any other cultural factor, human factors are significant in predicting between-organisation differences in the extent to which their productivity and profitability change over a three or four year period. These human factors include the extent to which employees:

- feel valued, trusted and supported;

- are enabled to exercise a high degree of autonomy in undertaking their work roles;
- are well supervised and trained.

The evidence suggests that employees' feelings about their work can have positive and sustained returns for an organisation's performance. Efforts to develop and promote employees' commitment to the organisation, satisfaction with their own jobs, and belief in the organisation's commitment to them as employees, can enhance both productivity and profitability.

The following human factors have an impact on organisational performance:

Employees'...

- satisfaction with their jobs;
- commitment to the organisation;
- attitudes to their individual workload;
- attitudes to working in teams;
- belief in the organisation's provision of training and development;
- belief in the fairness of their pay;
- belief in the organisation's concern with their welfare;
- belief in the organisation's fair treatment of the workforce.

Links between HR management practices and organisational performance

However, what are the management practices most likely to develop and promote the human factors which have a positive impact on an organisation's performance? The people management practices implemented in NHS trusts in England have been the focus of a study by collaborators from the London School of Economics, and the Departments of Organisational Psychology and Human Resource Management and the Universities of London and Massey.³² The study investigated which of a wide range of recommended and researched HR management (HRM) practices are in place in NHS trusts and how they are linked to performance. The results are summarised below.

- 1 The implementation of each *individual* HRM practice did not have a consistent impact on organisational performance: greater use of individual HRM practices was not consistently related to higher organisational performance.
- 2 The effects of the *full complement* of HRM practices on organisational performance were more consistent: greater use of a combination of HRM practices was significantly and positively associated with staff costs, productivity and unit labour costs.

These results suggest that the interaction or synergy between different HR practices may have consistent positive effects on these indicators of organisational performance (over and above the

impact of individual practices). For example, 3-5% of the variations in staff costs and productivity were explained by the combined impact of the HRM practices in place in different trusts. The authors' further calculations also made concrete the potential implications of these findings: if the HRM practices in place in a trust are rated as 1 standard deviation above the sample mean, then the particular trust would have approximately 10% higher productivity, 13% lower unit labour costs and 3% lower staff costs compared with the average trust in the sample. These results clearly have practical and financial implications.

However, the picture is more complex. All the HRM practices in combination did not have a consistently beneficial impact on the other performance outcomes examined - levels of labour turnover and absence, customer complaints and return on capital - and were in fact associated with less effective customer service (i.e. longer waiting times). This finding suggests the possibility that there may be trade-offs involved in the use of HRM practices; and that the impact of HRM practices may be more uneven than has often been assumed. This too has practical implications. It reinforces the view that effectively putting HRM principles into practice is complex and difficult, and even more so in decentralised organisations.³³ It also suggests that careful consideration should be given to the possibility that different groups of organisational stakeholders (managers, customers/service users, employees) may benefit more than others from the adoption of different sets of HR practices.

The crucial point is that while certain HRM practices are clearly influential, there is no research-based consensus regarding best HRM practice, either singly or in combination.³⁴ This is a priority for further investigation. Indeed, there is work in progress, led by Professor Mark Huselid, to help NHS employers understand the linkages between HR practice and organisational success.

Taken as a whole, however, the research evidence we have presented above makes clear that there is a complex and positive relationship between employee attitudes, organisational performance, and HR practice. Even if some elements of the relationship are unclear or unexpected, this is no reason for delay in following the pragmatic and practical approach that we have recommended in this report.

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