‘Dandelions’ by Fantasy Wire at Pensthorpe, Norfolk

‘An Insight into Contemporary Health and Care in the East of England’

A collection of contemporary Blogs, collated as a NICHE Monograph

PUBLISHED BY NICHE BETWEEN 2023-2025

NOVEMBER 2025

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1. Welcome

By Dr Jonathan Webster, Professor of Practice Development & Co-Director NICHE
November 2025

Welcome to this collection of NICHE Blogs collated as a Monograph written by system partners and collaborators who have journeyed with us (NICHE) over the past three years. Each of these Blogs captures our embedded focus on '**igniting**' creative thinking, to '**innovate**' creative exploration by looking at the here and now and what could be and '**embedded**' creative approaches in how we connect, work and learn together focussed on what matters to people and communities across our Norfolk and Waveney Integrated Care System. No matter how great the challenges may be in people's working lives repeatedly we see and experience a commitment to deliver the 'best' that people can be, both as individuals and as part of teams.

Each of the Blogs presented captures one of the afore mentioned key focusses of NICHE, they also provide an embedded focus on:

- The strength and value of **walking alongside people** in the 'real world' context no matter how complex or challenging the pathway may be. This focus on authentic, participatory approaches captures our value of Collaboration, Inclusion and Participation (CIP) which is a key underpinning principle of practice development and inclusive, person-centred transformation.

- The power of **shared learning** together to create new understanding and better outcomes for people and communities. The power of learning together and shared learning has been a 'golden thread' throughout all our work that both empowers and enables new ways of working.
- The importance of **compassionate communities as a measure of impact** that really makes a difference to individuals, the teams they are part of and the organisations in which they work. A key focus of our work has been the importance of compassion and self-compassion within cultures of practice that are inclusive, person-centred and authentic.
- **Humane moments in a fast-paced world** which can feel overwhelming and at times can be perceived as being at odds with our own personal and professional values. Being 'human' and recognising the values and shared values we hold as people is integral to our embedded research, evaluation and learning.

These Blogs presented in this Monograph aim to inspire critical, creative thinking releasing the potential of the possible to work and think differently.

2. Evaluating the impacts of delivering training, through the “Triple Bottom Line” lens

By Jonty Yazbek, Head of Quality Improvement, James Paget University Hospital NHS Trust
November 2023

What came out of the pandemic?

Debatably, one of the good things that came out of the Covid-19 pandemic was the adoption of video call meetings and virtual training opportunities. Before the pandemic I recall taking two hours round trips to attend an hour-long regional meeting for Smoking Cessation or Flu Vaccinations. Thankfully these were not very frequent because: (a) they took a big bite out of a productive day and (b) they left me cringing over the carbon footprint.

During the Covid19 pandemic, in order to contribute to the delivery of Norfolk and Waveney’ s highly successful vaccination rollout, we were attending daily meetings with colleagues from all over the county. Keeping up with the ever-changing regulations and coordinating the campaign would have been almost impossible without video conference calling. It enabled networking, idea sharing, peer support and agile working.

Since the onset of the pandemic our reliance on MS Teams meetings is now a staple requirement of our daily work routine. It allows for regular regional and sometimes national meetings. As we embarked on the development of The JPUH Research, Evaluation and Quality Improvement scholarship programme, which aims to enhance the capacity and confidence of our staff in research and innovation, we carefully considered the benefits of conducting the course virtually. We were mindful of the fact that healthcare provision itself is a significant contributor to global warming and environmental decline, accounting for approximately 5% of greenhouse gas emissions in the UK (Medical Schools Council, 2015). It led us to question whether we wanted to contribute to this issue? What is the triple bottom line?

Before dispensing with convention, we planned to first evaluate and run a pilot with face-to-face training sessions, with a thread of sustainability woven throughout. The JPUH Research, Evaluation and Quality Improvement scholarship provided scholars with ring-fenced time (one day a week for nine months) to develop a project specific to their area of work and a structured programme of monthly modules. Sustainable healthcare was included as a fundamental element within the programme design and across all scholars' projects. To benefit our own learning, as the programme facilitators', an evaluation-style sub-project was created and focused on exploring the sustainable healthcare impacts of the programme itself. And so, the "EnSuRES" (Exploring the Sushealth impacts of the JPUH Research, Evaluation and Quality Improvement Scholarships) project was born. Underpinning the evaluation was the 'triple bottom line'.

This phrase was first coined by John Elkington in 1994 who claimed the traditional measure of corporate success, Net income (The bottom line), is 'insufficient for measuring the true value of a firm's success. A company can be financially successful yet have a harmful social or environmental impact. The 'triple bottom line' takes all three elements into consideration as a measure of success. Recently, the triple bottom line is being considered as not only applicable, but essential to services such as health and care. Recently the NHS has developed the NHS NetZero plan and taken its NetZero ambitions one step further and built it into legislation by incorporating them into the Health and Care Act of 2022.

WHAT MORE CAN WE BE DOING?

At the outset of the programme the scholars were relatively naive to sustainable healthcare. Embedding this theme from the beginning was deemed of paramount importance, hence in module one, we incorporated an 'introduction to sustainable healthcare' session. We utilised publicly available resources from the Centre for Sustainable Healthcare and adapted them to build the session content.

For the EnSuRES evaluation of the environmental impact, we collected data across the whole nine-month programme. Based on travel to and from the monthly modules it was anticipated that the scholarship programme would generate 1,105 kgCO2e. However, with sustainable healthcare fresh in their minds, scholars took to using both public transport and seeking out car share opportunities by module two. This on its own equated to Carbon emissions avoidance of 121 kgCO2e, which brought our programme carbon footprint down to 984 kgCO2e. Taking into account scholar and programme facilitators 'usual travel to work' (which would have generated a footprint even if they had not been on the programme), it reduced the actual emissions generated by the course to 522kgCO2e. This is equivalent to about 10 million plastic straws or the annual "emissions" from 6 dairy cows.

The Financial impact attributed to travel costs was worked out to be £1811.56.

Having just emerged from the pandemic, the social aspect of the triple bottom line turned out to be of overriding importance. Half of our scholars and facilitators had been working from home or had hybrid working agreements in place during the pandemic. This was evident from the informal interviews which were held with the scholars to gather their feedback on the course. Questions included their perception of the course being face to face opposed to virtual. The social value attributed to the face-to-face delivery of the programme could not be emphasized enough by the scholars. Some of the feedback we received:

(S8) 'We were effectively isolated for almost two years, being back face to face reminded me just how important it is to be with people. Humans aren't meant to be isolated, are they? My mental health has improved so much because of this scholarship programme'

(S6) 'We've talked a lot about integrated learning across professions and organisations but it's not just that which is best being face to face, it's the way you can build relationships, understand personalities and see personalities gradually coming out of their shell. It just wouldn't have happened like this online…this is the thing I've valued the most.'

(S7) 'How to you describe value against something which is invaluable…?'

When evaluating the impact of the scholarship, under the "Triple Bottom Line" lens, the social benefits of delivering the course in person far outweighed the environmental and financial benefits which would have been gained if the course had been delivered virtually. All scholars stated that they had an increased awareness of sustainable healthcare and the link between their own practice and ways in which it could impact planetary health. Armed with this knowledge the phrase 'you can't unsee what you've seen' reverberated with the scholars and sustainability reflected in their projects.

It is recognised that the healthcare system is a major contributor to global warming, but as healthcare professionals we are also well placed to understand the science. We can't stop providing healthcare, but we can evaluate the ways we work and MUST evaluate it from multiple perspectives to truly understand the impacts of our actions and then take the most ethical course.

3. Achieving system and workforce transformation through co production

BY DR KIM MANLEY CBE, EMERITUS PROFESSOR OF PRACTICE DEVELOPMENT, UEA AND EMERITUS PROFESSOR CANTERBURY CHRIST CHURCH UNIVERSITY

APRIL 2023

CONTEXT

The health and care sectors are experiencing extreme demand and there are huge challenges with retaining and growing the vital workforce required to meet the needs of our populations in a way that is person and people centred, safe and effective, to provide continuity with a focus on what matters.

Integrated Care Systems (ICSs) have the legislative responsibility to commission an integrated approach to health and social care to meet population health needs and spend public money wisely (DoH,2022). This means breaking down professional silos through establishing systems leaders with the integrated skill sets to lead and drive culture change, facilitate effectiveness and sustainable improvement - all these skills are required for sustainable person-centred transformation (Manley and Jackson, 2020) with impact (Manley et al, 2022).

If a genuine collaborative, inclusive and participative approach is adopted by ICSs, then there is a real window of opportunity to begin a joined-up approach to transform health and care so that it meets changing population needs into the future. However, this can only be achieved by:

- ***Putting the person at the heart of what is driving health and social care improvement;*** along a care journey to keep them living well, close to or in their own homes is critical.
- ***Co-production with people to understand what matters to them in the context of where* they live**; particularly true of deprivation, (as health means different things to different people) and tackling the causes of poor health, to enable people to start well, live well and to die well.
- ***Skilled systems leaders for different care groups with the expertise and credibility required to***; break down silos across boundaries (Manley et al, 2016) support pathways nearer to people's homes; transform the workforce and culture of care, develop and value collective leaders; as well as evaluate and focus on what matters to people through place-based learning (Germain et al, 2022) and embedded research (Manley, 2022). These capabilities and the impact expected across systems are specified in Health Education England's Multi- Professional Consultant Capability and Impact Framework (HEE, 2022) and include developing the workforce, so capabilities are wrapped around the citizen rather than the profession, drawing on everyone's talents and expertise through co-production.

Within this blog, I provide two examples that modelled a co-production approach with multiple stakeholders along specialist care pathways across Integrate Care Systems:

1. Developing the care pathway for people following Traumatic Brain Injury (TBI) across one ICS, shared in a recent multi-professional publication from the South-East of England (Manley et al, 2023)
2. A project undertaken by the ImpACT Research Group at UEA[1] that focuses on the Eyecare workforce across Eastern region embracing 6 ICSs (Manley and Jackson, 2022)

CASE STUDY 1: PEOPLE WHO HAVE EXPERIENCED TRAUMATIC BRAIN INJURY (TBI)

With multi-professional colleagues across Kent and Medway ICS early steps in a journey of system transformation with people who had experienced Traumatic Brain Injury (TBI) have been co-created. Building on a ten-year history of partnership working (between people with TBI, carers, families, charities and professionals with expertise to help them), an integrated implementation and impact framework was developed through a co-production workshop. The framework resulting focussed on a) the care pathway across the ICS at the micro-level, and b) the macro -level, at the ICS itself.

The TBI pathway framework resulted in identifying the activities, enablers and outcomes in relation to what matters at the level at which service users and providers directly interact and interface with each other – the micro system level. Particular needs identified in the pathway included: (i) case managers who could provide continuity across all boundaries and partners to enable a joined up approach for the person and their family; (ii) the need for the workforce to explore, recognise and work with emotions as these related to what mattered to the person, carers and families; and,(iii) to measure what matters that informs learning and improvement rather than only what is mandated.

The macro system level at ICS level resulted in identifying the infrastructure and resources, workforce development and networks for developing place-based learning and improving cultures for optimal effect across communities to support and sustain micro systems. The macro level also embraced stakeholder commissioning, the development and evaluation of indicators of effectiveness based on what matters to people, communities and the workforce.

Systems leadership was identified as a pivotal lever and catalyst for achieving enablers and impacts, so key recommendations to ICSs identified the need to:

- appoint systems leaders with the prerequisite skill set to ensure a joined-up approach across ICS and pathways
- develop a multi-professional capabilities and career framework around the person's journey rather than around the profession
- create further opportunities for genuine engagement approaches with people and communities through co-production
- enable the co-evaluation of person centred, safe and effective resources and services through creating a learning culture across the system at every level inclusive of all

[1] ImpACT Research Group has now merged within NICHE Anchor Institute project workstreams

Other system wide enablers endorsed the need for people to be at the heart of the system; and workforce investment to meet these needs based on an integrated approach to learning and evaluation involving all in ongoing improvement and innovation. Workforce activities cannot afford to be duplicated because of a lack of 'joined-up' thinking, especially when there is a dearth in the workforce. The need for capability frameworks wrapped around the person's journey, rather than the profession, is based on assumptions that professions can complement each other but have areas of overlap. It is easier to identify where there are gaps in capabilities to be addressed rather than the number of professions required, and population profiles guide public health and services with a focus on care as close to people's homes as possible to improve outcomes and reduce demand on expensive acute services.

Case Study 2: People requiring support with Eye care needs

A region-wide project in East of England aimed to address population's eyecare needs. This is a high area of demand on health and care services in relation to an aging population. Supported by Health Education England and facilitated by the ImpACT Research Group at UEA, the project aimed to address the integration of eyecare workforce development within wider initiatives (across population groups/specialties) and strengthen workforce capability and capacity to deliver eyecare on a whole system basis across the region. The first phase used co-production approaches with all stakeholders across three workshops to achieve key outputs, namely:

- a shared purpose for eye care services across Eastern region and three identified priorities to achieve the purpose
- a development framework to guide implementation and evaluation of the shared purpose
- key relationships and approaches for providing person centred eye care across Integrated Care Systems (ICSs)
- the relationship between the people with actual or potential eyecare needs, their journey, the providers and the workforce capabilities required
- a detailed single multi-professional capability framework wrapped around the needs of people rather than the profession, with the aim of growing and using the capabilities near to peoples' homes as a driver for transformation
- the capabilities required for priority development
- the priorities for both upskilling and working differently
- recommendations for key stakeholders including Health Education England, Universities and ICS's

Two of the immediate recommendations for ICSs to enable this transformation again emphasised systems leadership as a catalyst for change:

1. Recruit or sponsor (from either inside/outside) the region OR grow aspiring multi-professional systems leaders in collaboration with HEE (EoE) through appointment of a multi-professional consultant practitioner or aspiring consultant. The practitioner would have the capabilities required for systems leadership, embedded research skills and the

proven ability to facilitate workforce transformation or be on a development programme to achieve them.

2. Support systems leaders to work with all partners and other ICSs to:

- Identify gaps to include:
    - gaps in capabilities required to meet community needs;
    - capability development in the community and general practice;
    - first contact, triage as close to home as possible, based on continuity of care, knowledge of person, and person as expert in own condition;
    - signposting, screening, gatekeeper and future role of Telemedicine.

- Develop community hubs across boundaries in accessible centres near to where people live.
- Agree key data bases to focus on what matters and evaluate progress and impact.

A SINGLE IMPACT FRAMEWORK FOR EVALUATING PROGRESS ACROSS ICSS

Both projects were achieved through co-production using practice development methodology with its focus on the lived values of collaboration, inclusion, participation and being person centred (Hardy et al, 2021). The impacts expected of transformation at different levels were identified to enable ongoing evaluation embedded in health and care practice with a strong focus on what matters to people. This inclusive approach to transformation has led us to identifying the need for a single impact/outcome framework, at ICS level, to reflect the health and care needs of local populations and what matters to people to guide on-going evaluation and progress of transformation coherently. Collating other funded evaluations from different sources also have the potential to enhance insights for learning and improvement with communities if guided by and further contributing to a single impact framework.

Whilst we all aspire to achieve longer term and larger scale health population outcomes, it is important to acknowledge how successfully implementing key building blocks, when initiating a journey of system transformation (e.g. developing effective person centred cultures (Cardiff et al, 2020),building person centred leaders (Jackson et al, 2021)and relationships) can act as a proxy(Manley et al, 2011) for these much harder to achieve outcomes. For example developing effective workplace cultures at every level of the system (and across it), can act as a powerful proxy for achieving high level population outcomes through the mechanism of enabling everyone to thrive and flourish, which in turn enables the development of high performing teams, the retention and development of staff, innovation and continuing 'true' co-production (Manley et al, 2011)

Over the past 15 years, members of the ImpACT Research Group and now the NICHE Anchor Institute, as national and international practice developers, have been tracking the impact of strategic pillars of leadership, culture change, facilitating person centred, safe and effective care, based on the collaborative, inclusive and participative approaches that underpins all it's work. We have distilled a preliminary impact framework (Manley et al, 2023) based on these insights to identify a single impact framework that identifies the building blocks, process

outcomes, sustainability features and longer-term outcomes across different levels of the health and social care system and society. Whilst this prototype framework requires further scrutiny, through exposure to constructive stakeholder challenge as co-production cycles with citizens, staff groups and evaluators, it has potential for guiding ICSs with establishing some of what we believe to be essential building blocks for effective systems and pathways. The framework also offers a process for capturing evidence and evaluating progress towards 'joined up' people centred health and care.

Broad impact themes (identified below) can guide evaluation of system level transformation, captured by ICSs, through relevant indicators and measures:

- Strategic alignment and integration across system
- Whole pathway commissioning – workforce transformation linked to peoples' needs, population mapping and changing contexts
- Co-production in service design, reviewing and measuring what matters
- Systems leadership and leadership at every level for effective workplace cultures
- System wide learning & improving support and governance

Both the recent TBI publication and eyecare project case studies endorse the importance of these themes when transforming systems and workforce to provide people centred health and care. The themes are also reflective of all our collaborative projects based on working with others to inform greater insight, understanding and evidence.

Conclusion

System and workforce transformation are integrated but the crucial success factor is the role of expert credible multi-professional systems leaders. The urgency for supporting development of these roles is currently being taken forward nationally by NHS England with priority care groups being identified as people with learning disabilities and autistic people; people with cancer and people with muscular-skeletal conditions. I am optimistic that these posts can make a difference, but only with timely support from ICS's. Hopefully we will soon see enough system leaders to inspire the workforce, so pivotal to transforming health and care sustainably.

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ACKNOWLEDGEMENTS

I would like to thank the NICHE Anchor Institute team, (formerly ImpACT Research Group) at UEA, for their critical comment and suggestions whist preparing this blog.

4. Rewilding our Workplace Cultures

By Dr Jonathan Webster, Professor of Practice Development and Co-Director NICHE
and
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October 2024

In this Blog, we plan to explore using the metaphor of 'Rewilding' how our Workplace Cultures are settings in which when the underpinning principles of 'Rewilding' are applied can grow, develop and thrive as nurturing, replenishing environments. We argue that Rewilding is not about 'neglect' rather it is an intentional, skilled act, drawing on an evidence base focussed on sustainability, nurturing and growth that supports eco diversity. In the same way we believe that creating workplace cultures that enable innovation in person centred practices to grow requires the same level of intention, commitment, understanding, reflection and learning which is enabled by skilled facilitation and is lived and experienced by all.

We both hold an interest (rooted commitment) to the importance of the natural world. We were able to start connecting our thinking to 'Rewilding' and 'Workplace Culture' through sharing and learning on the 'Leading and Facilitating the Development of Person-Centred Care and Cultures' residential programme commissioned jointly by Norfolk and Suffolk NHS Foundation Trust and the former Norfolk and Waveney CCG and delivered by NICHE at the University of East Anglia (NICHE 2023).

WORKPLACE CULTURE

Workplace Culture is the setting where care is delivered and experienced. Drennan defines Culture as, 'how things are done around here' (Drennan 1992). Our Workplace Culture can't be captured in a single Policy or Guideline, instead it is reflected in our behaviours and attitudes and the importance we place on all parts of our workplace where care is delivered and experienced. Importantly the setting where we interact and work with each other. We may have a written Vision Statement or Charter, however it is the shared values, attitudes and behaviours that help to grow a sustainable workplace culture that creates the 'best' for all that is reflected in our lived actions – we not only talk about our actions we live them too!

A number of high-profile reports and investigations have brought to the fore the centrality of 'culture' to quality of care, leadership and overall workforce satisfaction. The COVID-19 pandemic has shone a light on the importance of workforce 'wellbeing' and the importance of workplace cultures that are person-centred, safe and effective (Cardiff et al 2020).

Authors have presented frameworks and models that advocate different theoretical approaches. We are not arguing that one is 'better' than the other, rather the importance of developing a shared understanding informed by our collective beliefs that supports the growth and development of person-centred workplace cultures and authentic lived actions that enable person-centred practices to grow, thrive and flourish.

REWILDING

Rewilding is a holistic approach to conservation that seeks to revitalise and restore ecosystems by allowing natural processes to unfold with minimal human interference. At its core rewilding aims to return landscapes to a wilder states, promoting biodiversity, balance in ecology and resilience to environmental change. The concept of rewilding has gained momentum in recent years as traditional conservation efforts have often fallen short of addressing the complex challenges facing global ecosystems. This has turn lead to rewilding becoming increasingly difficult to describe with a single definition.

Habitat restoration is crucial to rewilding projects. Degraded habitats ecosystems are rehabilitated to provide suitable environments for a diverse range of species. This may involve removing new and invasive species, restoration of wetlands, replanting of native crops and the creation of wildlife corridors to reconnect fragmented environments and recreate habitats. Restoring structure and in turn function and species connectivity, rewilding aims to support both the recovery of flora and fauna. Restoration of key ecological processes plays a central role in rewilding projects, reintroduction of key species that have been lost or their populations vastly reduced aims to re-establish natural dynamics that human activity has disrupted. The reintroduction of lost species plays out in a cascading effect that has influence on other species and the ecosystem as a whole.

The concept of rewilding also places emphasis on the importance of minimal human intervention in the management of ecosystems. Rather than relying on traditional conservation methods that often involve invasive management and control, rewilding advocates for allowing natural processes to govern the dynamic within the ecosystem. This does not mean abandoning human involvement, rather adopting a more hands-off approach

that prioritises the restoration of natural processes and the capacity of the ecosystem to self-regulation. This places emphasis on the need for rewilding projects to planned with intent.

While rewilding holds great promise for biodiversity and conservation and the restoration of environments, it is not without its controversies and challenges. Concerns about potential conflict with human activity, such as agriculture and urban development, as well as questions about the feasibility and ethics of reintroducing certain species, must be carefully considered and addressed. Furthermore, successful rewilding requires long-term commitment, professional interdisciplinary collaboration and community engagement to ensure the coexistence of humans and wildlife in the shared landscape.

EMERGENT SYNERGY IN THEMES – 'REWILDING OUR WORKPLACE CULTURE'

To rewild our workplace cultures that will flourish and grow requires intent (to make a difference), facilitation and a vision to make real opportunities for person-centred cultures that are effective. Rewilding and creating workplace cultures that enable innovation doesn't come about by neglect they require a shared vision and purpose that is owned and nurtured by all. Creating effective workplace cultures that are person-centred requires the lived value of inclusivity and collegiality in which all are included and valued requiring a commitment to practice – centred (embedded) action that enables and empowers all that is critically informed through reflection and ongoing critique.

Leadership and shared governance plays a central role to rewilding our workplace culture in which a culture is created that questions and supports in equal measure and uses every opportunity to learn therefore developing greater insight and understanding which leads to improved effectiveness and better person-centred outcomes. Having a vision is central to this, however being aware of unintended consequences is key. For some, rewilding may be perceived as about losing control – a neatly manicured garden in which the eco system is controlled and tightly managed is the opposite to a rewilding approach that may not be neat around the edges however importantly will require as much effort and intent to maintain its health. We pose the question, *'what is healthier, the neatly managed garden or the rewilded area that is supporting a thriving eco system to grow and develop?'* Some people may decide that rewilding is not for them similarly an effective workplace culture that is person-centred may be at odds with personal values and beliefs in which they believe that as the 'professional' they 'know best'.

We argue that that by drawing on the metaphor of 'rewilding our workplace culture' all can thrive, grow and develop leading to increased effectiveness in our workplace cultures that are person-centred and effective. We recognise that at times this can require a leap of faith and trust in 'what can be'. We also recognise the importance of a vision that is embedded in the practice setting and how important it is to give people the 'permission' (if permission in its many different forms is needed) through not only 'saying' but 'doing' in which the culture and context of practice and learning supports, innovation, development and person-centred transformation.

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5. Understanding Global Health Challenges and the Importance of Cultural and International Knowledge Mobilisation

By Dr Sally Hardy, Professor of Mental Health and Practice Innovation and Director of NICHE
October 2024

NICHE has been advancing partnerships internationally through working with countries that share a common theme of addressing health inequalities across coastal, rural and isolated communities. We have seen our NICHE fellows attending international conferences, sharing their work, and ensuring lessons learned from evidence-based innovations that can be scaled and utilised in other countries. Our evidence reveals how globally we are dealing with similar issues of workforce skills and attributes to maximise system level transformation.

I have had the privilege of working overseas on a series of projects exploring mental and maternal health awareness, addressing the growing impact of climate change on health inequalities. These projects have *ignited* new understandings and highlighted firsthand, how entire communities can be devasted by the impact of severe weather (e.g., floods, fires, droughts and tornados for example), alongside the impact of manmade disasters (e.g., bombings, shootings, war crimes) that can leave whole communities in traumatised states. These two aspects of our changing global patterns are termed as natural and man-made disasters.

According to Cvetkovic et al, (2024), during 1990 – 2024 there have been a total of 25, 836 disasters recorded worldwide, of which 70% were natural, and 30% man-made. They go on to identify how droughts and floods are the most devastating in terms of human lives lost, and long-term economic impact (as livelihoods are lost and food crops, water security is destroyed). Their paper highlights an urgent need for *innovations* in research and disaster management strategies, where countries are learning from and with each other, in how best to address the challenges and impact these disasters leave in their wake.

The effects of climate change raise greatest adversity to those with significant health related inequalities (Mooney, 2021; Dodd et al, 2023). Yet, there has been little *innovation* in research and policy change despite significant evidence of increasing and escalating catastrophic consequences of traumatic global events. Political strategic direction for health and social care aims to develop an integrated, whole systems approach, positioning people, their communities and what matters to them, at the heart of reform. This involves collaborative, citizen-centred effective strategies, engaging targeted resources (i.e., the health and social care workforce) effectively across place-based systems (NHS 2016, 2019, 2020). Advancing this agenda requires a workforce with the knowledge, skills and expertise to address and work from a trauma informed agenda, engaging their local communities with sensitivity and humility, in binding expertise to co-create and *embed* advances in what really

does matter in terms of culturally sensitive health agendas.

The World Health Organisation's (WHO) global health strategy points to the creation of approximately 40 million new health and social care jobs globally are needed to ensure a broad range of health services can deliver what is necessary to ensure healthy lives for all (WHO, 2016:13). Yet how best to prepare the workforce to achieve culturally sensitive innovations also remains a limited area of research and knowledge.

NHS England funded a Mental Health Awareness programme in Sri Lanka. Over the past few years the programme has been delivered to over 300 nursing students and practitioners, as a week-long education programme that has been highly evaluated. Since that programme began, we have managed to build several key relationships with partners in Sri Lanka, where we are now exploring student and faculty exchange, and working with local charities to advance practice changes. For example, in my most recent visit, I had the privilege of visiting the Eastern Province of Sri Lanka and attending a public health clinic and the regional hospital. The staff were keen to share the great work they were doing in managing an increased rise in Leprosy and other skin conditions, (they identified as associated with contaminated water) plus how their interventions with local communities had a positive impact on low birth weights and child malnutrition. Perhaps the most impressive was meeting a group of mothers and their young children, who had engaged with the World Vision project PDHearth[2] where cooking and hygiene activities were showing benefits in not just children's weight gain, but in how empowered the mothers were in speaking passionately and discussing openly the local health and wellbeing needs of their communities.

Working with the Caribbean via our connections with the University of West Indies (UWI) has focused on maternal health and midwifery education. We visited UWI MONA (see NICHE newsletter 8) and facilitated two workshops; one on perinatal mental health and the second, on the importance of leadership in service level improvements with our wonderful colleagues from the Caribbean Nursing and Midwifery Association[3] based in the UK. We had the privilege of visiting the maternity hospitals, and discussed the changing patterns of maternal health and wellbeing, plus how staff were engaging with communities to understand more of the local issues of water and food security as weather patterns change. Dehydration has a devastating impact on mothers and their unborn babies, which had led to the regional neonatal unit being one of their busiest units in Jamaica, was just one example we observed and discussed.

In UWI Trinidad and Tobago, I was invited to facilitate a stakeholder workshop looking to develop a new MSc in Trauma and Mental health, where we explored the vision, values and associated requirements of a curriculum that could prepare the workforce for future disaster management and engage in trauma informed approaches with communities. The two days were a brilliant reminder of how bringing people together with a shared vision for improvement, brings out the passion and creative ideas. The groups worked tirelessly to

[2] World Vision PD Hearth project: https://www.worldvision.org.uk/about/blogs/how-world-vision-combats-malnutrition/ (last accessed 9/10/24)
[3] CNMA UK: https://cnmassociation.co.uk (last accessed 9/10/24)

shape and share expertise required to make the curriculum highly valuable to future needs of communities across the Caribbean. (You can read more of that event in our next NICHE newsletter).

Norfolk may seem a 'world away' from these countries, however our goal in NICHE is to share our learning across and from our partners, locally, regionally, and internationally. We have seen real synergies in themes and opportunities for learning and collaboration with all our partners. Our work has local significance but global relevance. There is still so much to learn from understanding the global workforce, and the knowledge mobilisation that working internationally brings. We aim to continue to spread the ability to share knowledge and explore a growing evidence base with others, as we live and work together to inform and shape our future.

According to Fadiloglulari, (2023)[4] there are several benefits to being culturally aware that impacts many aspects of our lives and wellbeing:

- It makes you more socially aware. Being culturally aware raises knowledge and understanding that there are different ways of perceiving things. Engaging diverse participants to achieve activities brings new insight and added value to any accomplishments.
- It can improve your communication skills. Being aware of other cultures and expectations in terms of what is offensive in some cultures, and learning how to behave to develop relationships based on mutual understanding are crucial aspects to ensuring you can be relaxed and comfortable around others.
- It awakens new perspectives. Cultural awareness challenges our assumptions, and ensures you are open to having new perspectives on things, and a broad horizon of possibilities. Empathy and decision making are known to improve when people travel and explore new cultures. Creating meaningful connections is all that matters.
- Being culturally aware can be useful at interviews, as it shows employers you have gained experience and can work with people from different backgrounds and cultures than your own.

Studies have shown health care students bring back a number of critical insights in terms of understanding the differences between the UK health system and other countries, when experiencing overseas placements (Browne, 2020; Grant and McKenna, 2003; Green et al, 2008), returning to the UK with renewed appreciation of the National Health Service (NHS).

Multiple stakeholders were and are required when dealing with global health emergencies and this was seen and experienced most publicly during the COVI-19 pandemic. Yet more work is needed to advance our workforce capacities in learning and sustaining improvements and innovations achieved. NICHE will continue to engage with our international collaborating partners to work together to address the rise in global health challenges. I encourage you all

[4] What are the benefits of cultural awareness? https://www.goabroad.com/articles/benefits-of-cultural-awareness

to explore your own communities and to experience the joy of engaging with new cultural experiences, whether at home or overseas. I know the work I and colleagues have been participating with has changed us in ways we never imagined. It has brought a renewed sense of purpose when working to achieve humane kindness and compassion in what can sometimes feel like a very harsh reality of global disaster and persistent change.

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6. Ignite, Innovate and Embed. Three ways to Create Change and Energy in Health and Social Care Systems

BY JO ODELL, SENIOR RESEARCH FELLOW, NICHE
SEPTEMBER 2024

I read a blog entitled ' Siloed, unsupported and hindered – the reality of innovation in the NHS and social care', from the Kings Fund (April 2024), Siloed, Unsupported And Hindered – The Reality Of Innovation In The NHS And Social Care | The King's Fund (kingsfund.org.uk) https://www.kingsfund.org.uk/insight-and-analysis/blogs/siloed-unsupported-hindered-innovation-nhs-social-care in which they describe a series of events that brought together over 100 people to connect and share experiences of innovation within a system described as "much under pressure".

The key messages from this blog that resonated with my own experiences were:

- Participants shared a sense of frustration around innovation and around making change happen felt very difficult.
- Innovation happens not because of, but in spite of the system and is only possible due to enthusiastic individuals "who go over and above". The system and its processes are seen as resistant to change due to workload pressures, culture, organisational structures and leadership.

- There feels like there is “bunker like” mentality that supports a culture in which there is no space or “head room“ to do or think differently.
- There is a sense of isolation and siloed working often in teams, services, organisations and across the system. There is a sense that power dynamics, distrust and suspicion often perpetuates this sense of isolation.

The authors of the blog finish by saying “But it doesn’t have to be this way. Staff knowledge, expertise and passion to improve services is an untapped well of innovation energy. To have an NHS and social care that is able to innovate and thrive means changing how we make change happen.”

And here at NICHE that is exactly what underpins the way we work. The three words that inspire our work are the values of:

- IGNITEing people’s passions, ideas, energy and collaboration with each other and across teams, organisations and systems.
- Creating safe psychological spaces for people to INNOVATE, develop new insights, knowledge and confidence to enable action with their ideas.
- Enabling people to stay as close to their existing roles in clinical practice and EMBED their research, evaluation, and innovation activities in their day-to-day work with their teams and the people they care for.

I have listed some examples of how NICHE is living these values to enable people to thrive and innovate within a number of different contexts.

EXAMPLE 1

The Embedded Scholarship programme. Three Cohorts will have been funded by NICHE and led by the James Paget University Hospital (JPUH). Upon completion, circa 43 participants will have completed the programme from across the Norfolk and Waveney Integrated Care System, with the opportunity to have one day a week, for 9 months to focus on an embedded local project of their choosing. Examples of projects that have emerged from this programme are very varied and comprehensive and you can see some examples in the poster presentation brochure here from Cohort 1: Reports and Publications - Groups and Centres (uea.ac.uk) or read about them in the blog section. https://www.uea.ac.uk/web/groups-and-centres/projects/niche/news

EXAMPLE 2

THEO (Therpeutic Optimisation) is an exciting and complex intervention research study that will be working with two ward settings in real time. The participatory action research that forms part of the embedded intervention will involve recruiting volunteer co-researchers from the existing ward nursing team as experts in this innovation. The co-research team will have time and space to work in collaboration to “look” (i.e., gather evidence about a situation or context), “Think” (i.e., reflect together to critically analyse the evidence), then “Act” (i.e., develop a shared action plan, from which to take informed action). This process will generate both knowledge and action to improve the experience and care for both the ward staff and

the people who receive care on the ward. It is hoped that the blended approach being taken with this research will provide a model for innovation as well as embedded research across the Norfolk and Waveney System.
For more Information:
https://www.uea.ac.uk/web/groups-and-centres/projects/niche/therapeutic-optimisation

EXAMPLE 3

NICHE offers a five-day residential programme, "Leading and Facilitating the Development of Person-Centred Care and Cultures" for participants who are working at team/ward leader level. The programme provides an intensive experiential period of learning and not 'just another teaching or training' event. Instead, the focus is on a safe facilitated space, uses an active learning approach and provides an infrastructure to enable supportive and connected relationships. The programme challenges leaders to explore embedding person-centred care and cultivating compassionate leadership whilst fostering a supportive and effective workplace culture. Following the programme, twelve months of mentorship was also provided to enable participants to take their learning back into their teams to further influence change focussing on their 'commitments to act'.

You can read the evaluation report of the programme that was commissioned by Norfolk and Suffolk NHS Foundation Trust and the former Norfolk and Waveney Clinical Commissioning Group in 2023. nsft_-niche-residential-programme-final-report.pdf

In all the above examples, NICHE values shine through which are "working with people, rather than doing to people". We work with people in place, embedded within their local and existing contexts and roles, whilst they learn. Learning is dynamic and embedded in the workplace and their professional practice. We work to enable space for people to feel safe to challenge themselves and to find their "tribe", where they can grow and flourish. So finally going back to the Kings Fund blog I discussed earlier, at NICHE we are finding ways to "tap into the well of innovation energy" and are really starting to see the impact and outcomes spread across the Norfolk and Waveney system as highlighted in the NICHE latest Impact Assessment report. niche-impact-final-report-august-2024-1.pdf

7. Stewarding Creative Arts, Culture and Heritage as Restorative Citizens

By Laura Drysdale, Director, The Restoration Trust
January 2024
Website: http://restorationtrust.org.uk/

The Restoration Trust is a charity organisation based in Norfolk and Waveney supporting people with mental health issues through building effective partnerships across heritage, culture, arts, health and social care. Our work involves people living with mental health challenges, facilitating their connection with our local and national heritage. What we mean by 'Heritage' can be defined as literally everything we have inherited; including our wonderful historic landscapes and townscapes, our green (e.g., woods, parks, meadows) and blue (rivers, lakes and the sea) spaces[5] our historic treasures, artefacts, things and memories.

We live in an historic, old country[6] with an excess of ancient places to explore, archives to research, stories to record, treasure to excavate, so the past is always present here. There is a wealth of knowledge and expertise we can call upon to bring history to life, learning lessons from the past through people such as ecologists, archaeologists, archivists, artists, musicians and writers, who are rich resources in themselves.

We don't want to claim that heritage offers more wellbeing benefits than any other kind of asset, but what we do know is that research is building an evidence base for us to truly believe that accessing cultural heritage can be a part of how we optimise health and wellbeing. Our history is part of everyone's DNA, these heritage assets are an integral part of our daily lives and the basis on which we have shaped our locally vibrant, diverse and distinctive communities.

The Restoration Trust's task is to overcome the barriers that prevent some people from enjoying heritage experiences. Through effective, mutually, respectful partnerships, and accessing funds and expertise, we can collaborate with health and connect with heritage providers to tackle intractable inequality. Given such a generous supply of heritage against an escalating demand for health and care services, it makes sense to match one with the other.

It is encouraging for those of us operating at the interface between community assets and health to see NICHE integrate nature, creativity and heritage into its work. From a health

[5] University of York Green and Blues Spaces: https://www.york.ac.uk/healthsciences/closing-the-gap/research-themes/green-and-blue-space/#:~:text=This%20theme%20is%20all%20about,as%20rivers%2C%20lakes%20and%20sea (last accessed 25.1.2024)

[6] Oldest footprints found in Happisburgh. https://www.theguardian.com/science/2014/feb/07/oldest-human-footprints-happisburgh-norfolk#:~:text=The%20oldest%20human%20footprints%20found,stretches%20of%20the%20British%20coast

perspective, our Heritage Link Work social prescribing pilot in Great Yarmouth and Waveney has found that for our participants:

- 56% noted an improvement to their mental wellbeing,
- 18% reduced their use of health services,
- 28% reduced their medication usage, and
- 50% have been more physically active.

The project has also improved social connections with:

- 72% of our participants having met new friends and
- 50% of participants socialising with someone they met on the project outside of group activities.

From the heritage perspective, we want to build upon these encouraging percentages to help organisations fulfil their social purpose.

Another project we have initiated is our long-standing Change Minds[7] partnership. This project links the Norfolk Record Office with local health and care partners. We have worked with prisoners, people with serious mental illnesses, vulnerable young people and people who are socially isolated. This aligns the archives service with Norfolk County Council's vision that 'no one is left behind'. Facilitating access to the Record Office and getting up close and personal with the archives themselves has reduced feelings of exclusion and boosted peoples' confidence. Change Minds has substantial evidence from which to demonstrate how looking to the past helps build creative, purposeful connections in the present. The Change Minds Project is being delivered across other parts of the UK, and we would be keen to work with anyone interested in taking this established format forward within your areas. Do get in touch.

We all know that times are hard for the 120,000+ people living and working in deprived parts of Norfolk, where many of our members are located. In isolated rural places and deprived coastal towns and villages, people can feel abandoned by authorities, who themselves have increasing pressures to reduce spend, and have a limited workforce from which to address escalating need. Climate change has literally taken the ground[8] from beneath our as our natural world shows signs of disintegration. Coastal cliffs are falling into the sea and rivers are flooding, removing valuable arable land and affecting local businesses, as houses and incomes are lost, which inevitably negatively impacts our mental health.

In the media we can read reports of institutional scandals across almost all our public sector organisations[9]. The local mental health care NHS trust has been accused of failures to record

[7] https://changeminds.org.uk
[8] The Guardian newspaper (11 March 2023)
https://www.theguardian.com/uk-news/2023/mar/11/pulling-down-of-coastal-houses-because-of-erosionhttps://www.theguardian.com/uk-news/2023/mar/11/pulling-down-of-coastal-houses-because-of-erosion-will-harm-norfolk-economywill-harm-norfolk-economy
[9] Public Sector Trend Predictions 2024 (30 November 2023)

the cause of death of more than 8,000 patients[10]. Ofsted Inspections are causing education staff to take their own lives[11]. Most recently we read in the press that the police ignored a 999 call with devastating results[12], to name but a few examples.

Sir Michael Marmot, the author of yet another damning report on the social determinants of health, states that there has been little improvement in the past decade[13]. He calls for political attention across eight principles[14] which include early years (our children and young people), those in employment (who are still identified as in poverty), living standards, communities, ill health prevention, discrimination and environment sustainability.

The Restoration Trust cannot compensate for these infrastructural disasters. Yet, like 19th century asylums or 20th century therapeutic communities, we can offer some respite and consolation, creating our own version of a modern form of 'asylum' as a safe space from which to find ourselves living and functioning well again, in a trusting connection with individuals, communities and benign institutions.

We are keen to continue to work with NICHE to address the shocking social aspects that damage our mental health and wellbeing. Several ideas and initiatives are underway, such as setting up the Norfolk and Waveney Arts and Health Collaborative[15] . We need to seek funders willing to help us address these cultural, heritage and health related issues as a matter of urgency. Then people can be positively engaged as restorative citizens, stewards of our heritage, landscapes and each other's longevity.

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[10] The Guardian newspaper (21 January 2024)
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[11] Head Teacher takes her life pre Ofsted inspection (7 December, 2023) https://www.bbc.com/news/uk-england-berkshire-67620626#

[12] Police fail to respond to 999 call. (24 January 2024)
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https://www.instituteofhealthequity.org/resources-reports/embedding-the-marmot-principles-in-tendringhttps://www.instituteofhealthequity.org/resources-reports/embedding-the-marmot-principles-in-tendring-essex/embedding-the-marmot-principles-in-tendring-essex.pdfessex/embedding-the-marmot-principles-in-tendring-essex.pdf

[15] https://norfolkartsandhealth.com

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RESTORATION TRUST PUBLICATIONS AND RESOURCES

- Our publications can all be found on our website: https://restorationtrust.org.uk/our-impact/
- Creatively Minded and Heritage is one of a set of excellent arts and health reports published by The Baring Foundation. https://baringfoundation.org.uk/resource/creatively-minded-and-heritage/.
- Historic England's Wellbeing Strategy is significant and it has a bibliography of useful publications. https://historicengland.org.uk/content/docs/about/strategy-wellbeing-heritage-2022-25/
- The Creative Health Review published by the National Centre for Creative Health is a valuable update on the 2017 Creative Health Report by the All Party Parliamentary Group on Arts, Health and Wellbeing. https://ncch.org.uk/creative-health-
- The National Academy for Social Prescribing has some useful information and this evidence review. https://socialprescribingacademy.org.uk/media/5xhnkfwh/how-arts-heritage-and-culture can-support-health-and-wellbeing-through-social-prescribing.pdf

KEY ORGANISATIONS THAT PEOPLE CAN LINK WITH:

- The National Centre for Creative Health: https://ncch.org.uk/
- Culture Health and Wellbeing Alliance: https://www.culturehealthandwellbeing.org.uk/
- Norfolk and Suffolk Culture Board Annual Report: https://nationalcentreforwriting.org.uk/wpcontent/uploads/2023/07/Culture-Drives-Impact-The-New-Anglia-LEP.pdf

8. Leading And Speaking Up

BY ALISON THOMAS, FORMER LEADERSHIP DEVELOPMENT LEAD, NORFOLK AND SUFFOLK NHS FOUNDATION TRUST
JANUARY 2024

A decade ago, the Francis Report[16] was published following the public inquiry into the failings and hundreds of patient deaths over a number of years at the Mid Staffordshire Hospital. And yet as the Lucy Letby case recently demonstrated, unexpected deaths of vulnerable patients are still occurring and concerns that are raised by staff continue to be ignored. On a personal level if we had concerns about the care of one of our family members or a close friend, we would do everything in our power to our raise concerns and to persist until something improved. So why as a healthcare professional is it so hard to speak up and to effect change? And we know that it is still hard to do so because the data from the annual NHS Staff Survey[17] shows that.

INTRODUCTION

In this blog I'll look at speaking up in the NHS post the Francis report and the actions that were taken then and the current state of speaking up in NHS. I'll explore the consequences of not

[16] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – Robert Francis QC, 2013
[17] Working together to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com)

speaking up. I'll then highlight what role leadership plays in enabling staff to speak up and what responsibilities leaders have to make change happen.

SPEAKING UP

What do I mean by speaking up? The phrase covers a number of actions: raising a concern, making a disclosure, making a complaint, whistleblowing, taking out a grievance and suggesting an improvement.

Following the publication of the Francis Report in 2013, the NHS introduced Freedom to Speak Up Guardians in NHS organisations in 2016. Their role is to ensure that staff have a route to be able to speak up about anything that concerns them about working practices, in particular in relation to patient safety. There are now over 1000 Freedom to Speak Up Guardians in NHS Primary and Secondary Care, in independent sector care organisations and national bodies.

A report by the National Guardian Office in June 2023[18], Fear and Futility – What does the Staff Survey tell us about Speaking Up in the NHS[19], highlighted that only 61.5% of staff nationally felt safe to speak up and that if they did speak up only 48.7% felt that their concerns would be addressed (a drop in score since 2021).

Staff in organisations in the East of England scored least well on the four Freedom to Speak Up questions compared to NHS staff around the rest of the country. It is perhaps not surprising that staff experience isn't the same in any organisation and that there are particular groups of staff who feel even more concerned about speaking up. These include staff in different occupational groups, such as staff working in ambulance trusts, midwifery, doctors and dentists and bank staff. And staff with protected characteristics such as ethnicity, gender and long- term health conditions also feel less confident to speak up. There can also be practical difficulties for some groups of staff such as those working on nightshifts.

The Messenger Review (2022) set up to examine the state of leadership and management in the health and social care sector stated that "In the NHS, we sensed a lack of psychological safety to speak up and listen, despite the excellent progress made since the Francis Report. We would observe that the Freedom to Speak Up initiative can be narrowly perceived through the lens of whistleblowing rather than also organisational improvement, and we would encourage a broader perspective."

BARRIERS TO SPEAKING UP

The biggest barrier to speaking up seems to be fear, which manifests itself in different ways. There's fear of not being believed, the fear of being seen as a troublemaker, the fear of damage to personal career prospects, the fear of retaliation or being ostracised.
Paul Whiteing, Chief Executive of the patient safety charity Action Against Medical Accidents

[18] Fear and Futility – What does the Staff Survey tell us about Speaking Up in the NHS – National Guardian Office, 2023

[19] Leadership for a collaborative and inclusive future – General Sir Gordon Messenger (The Messenger Review) June 2022

said that "There is sadly a long history of whistle-blowers who speak up being ignored, side-lined and blamed, and sometimes forced to pay the price of their efforts with their livelihood". When even senior staff in the NHS raise concerns, as in the Letby case, and they are ignored, how likely is it that staff earlier in their career or in a more junior role will take the risk and speak up?

CONSEQUENCES OF NOT SPEAKING UP

But the consequences of not speaking up can, quite bluntly, be the matter of life or death for patients needing health care.

THE ROLE OF LEADERS

Leaders have a key role in creating a psychologically safe workplace that gives staff the confidence that if they speak up, they will be listened to, and action will be taken. That's easily said and perhaps harder to do but I suggest that leaders start by talking about patient safety from their own personal perspective. If a leader expresses their concern about the care their loved ones have experienced or may experience in the future, it enables human connections to be made by sharing concerns and vulnerabilities. And that helps build trust which is the basis of creating psychological safety. This needs to happen at all levels in an organisation. Staff need to feel that they can trust their immediate line manager to listen and then act. But they also need to hear that same concern for patient safety expressed by the leaders at the top of the organisation and for that to be role modelled at every level in between. Transparency about the outcomes of actions taken to address concerns will also build trust and confidence that it is safe to speak up. Once staff have spoken up, leaders have a critical role and that is to take every concern seriously. They should use data to assess the concerns that have been raised and to look at trends and patterns. They should be dispassionate about the people involved and not allow personal beliefs that 'someone is too nice' to commit the alleged offences to dominate. Instead, be guided by the data and evidence.

In the trial of the Letby case it was clear that by tracking who was on duty when the babies died that she was the only nurse on duty in every situation. As a non-clinician, confronted with that information, it would have made me at least ask questions and do more investigation. Using data helps us overcome our unconscious biases. It helps us to focus on the facts, rather than our decisions being swayed by our personal perceptions of the situation. If a data led approach was at the forefront of leaders' minds when concerns are raised and in subsequent investigations, it is likely that patient safety will be improved.

SUMMARY

In summary, all of us that work in health and social care have a responsibility to speak up and raise concerns about any unsafe practice or culture. In fact, the table of recommendations in the Francis Report starts with a simple statement. "These recommendations require every single person serving patients to contribute to a safer, committed, and compassionate, and caring service." We must have the courage to put safety concerns we spot above our own personal concerns about the consequences of doing so. But as we have seen there are significant barriers that stop people doing so.

To make it easier to speak up, the primary responsibility lies with anyone in a leadership role

to take proactive steps to create a psychologically safe culture, which will in turn lead to the erosion of the barriers stopping staff speaking up. They also need to have the courage to listen with an open mind to the concerns that are raised and search out the data that will provide the evidence or not for the concerns which have been raised. If this doesn't happen, with consistency in every part of the NHS, then sadly, some patients will continue to be at risk of experiencing poor quality care or serious harm.

9. Mind the Gap: Workforce Planning for Integrated Care Systems

By Dr Sally Hardy, Professor of Mental Health and Practice Innovation and Director of NICHE
May 2023

As part of the Coronation events, King Charles 111 and Queen Camilla provided the voice over announcements for both London Underground during the Coronation weekend (May 6-8, 2023), including the famous, 'Mind the Gap' announcements for railway stations across the UK[20] . This news item was inspiration for using that very phrase to discuss workforce planning gaps, and other workforce issues we are considering in our integrated care systems. Some of these workforce patterns are being seen on a global scale and are touched upon in this month's blog.

Introduction

The World Health Organisation in their workforce strategy identify how they remain ' deeply concerned' by the rising global workforce deficit, and the mismatch between the supply, demand, and population needs for health workers, now and in the future, which are major barriers to achieving universal health coverage' (WHO, 2016: Global strategy on human resources for health: workforce 2030: pp2).

In a House of Commons Health and Social Committee parliamentary report, focusing on Workforce (published 25 July 2022) it is explicitly stated that 'the National Health Service, and Social Care Sector, are facing the greatest workforce challenges in their history' (pg. 1)

The UK Government delivers its workforce programmes through commissioning NHS England (which has now merged with Health Education England, who were responsible for training and education) to produce a 15-year workforce plan. This workforce plan aims to ensure the workforce is available 'in the right numbers, to deliver excellent healthcare and drive improvements' stated in the government response document (expert panel evaluation, published 18 April 2023). In a subsequent response document this workforce plan is expressed as necessary to support the Integrated Care Boards, to set out what they can do to grow and support the workforce, looking beyond the NHS to take a one workforce approach (pg. 5). However, these workforce plans are delayed, due to a refocus from a supply and demand approach to a renewed focus on productivity measures.

The COVID-19 Pandemic Context

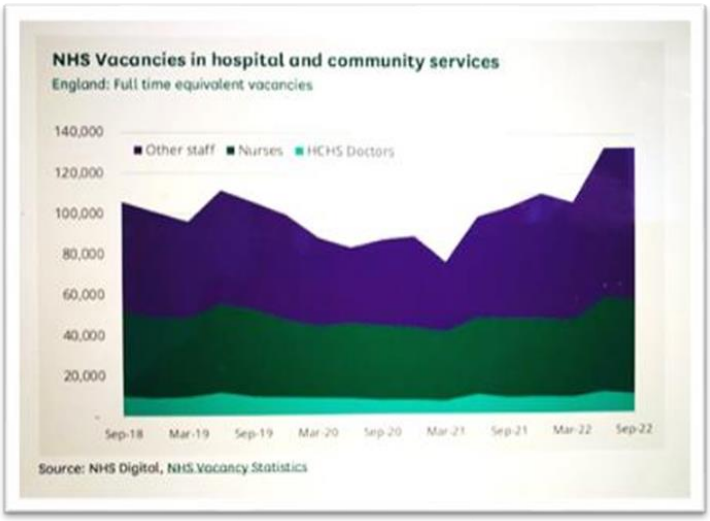
The COVID-19 pandemic exacerbated an already fragile global health and social care workforce, with widening evidence and experiences of impact on health inequalities (ref WHO, 2016; Marmott, 2020). Across the world, economies, communities' health and

[20] https://www.bbc.co.uk/news/uk-england-london-65495580# (6 May 2023)

wellbeing have all been affected by the COVID-19 pandemic. COVID related infection has resulted in higher patient acuity, which in turn is contributing to longer hospital stays. Alongside this, we have a backlog and rising lengthy waiting lists, arising from severely disrupted services during the national lockdowns, all of which continues to impact on productivity and recovery today.

Galanis et al, (2021) study explained that burnout, during the pandemic, was identified in high numbers of staff, who were experiencing emotional exhaustion, depersonalisation, and reduced feelings of accomplishment, associated with decreased social support whilst working throughout the pandemic, and an identified increased workload. Longer term data is revealing how mental health remains a major cause for staff being on long term sickness. According to NHS Digital data the most common reasons for sickness and absence being recorded are to do with anxiety, stress, depression and other mental health related problems, equivalent to 520,000 days lost due to mental health in October 2022 alone.

The chart below shows the distribution of vacancies among staff and is taken from the NHS digital vacancy statistics (taken from The NHS workforce in England House of Commons report 21 February 2023).



A pattern of ongoing workforce pressures not just in the UK, reflect similarly high rates of staff turnover. For example, across America's working population, associated with the COVID-19 pandemic., saw a mass exodus subsequently identified by Gahdhi and Robison, (2021) as the "Great Resignation". A record-high number of resignations of this scale, emphasised by a remaining high number of unfilled vacancies, despite concerted efforts to attract in and retain staff in health and care professions, has become a familiar workforce pattern.

MIND THE GAP

April 2023 saw announcement that funding for the social care workforce would be halved, with an increased focus on investment for accelerating the use of digital technology across

the care sector over the next 2 years[21]. NHS providers[22] responded to the social care workforce funding announcements, also stressed that there remain significant vacancies in the social care workforce, and whilst the digitalisation for better data was a positive move, this would still need the right staff with the expertise to achieve this ambition and make it work, as a beneficial investment process for improved person-centred care provision.

Significant evidence exists to indicate a direct correlation between the qualification level staff have, and their contribution to positive patient outcomes (Twigg et al, 2019, Aiken et al, 2018; Griffiths et al, 2014; Blegen et al, 2011; Park et al, 2012). The potential impact on quality care and productivity being seen from any workforce plan that has a focused on replacing registered practitioners with support worker roles, goes against this substantial evidence base. In our recent work to explore the introduction of associate worker roles, in specialist care settings our conclusion was that it is still too early to fully indicate direct links to quality and safety aspects of care outcomes with newly introduced level of roles. However, roles such as this were found to provide an important opportunity to support new care delivery models, based on integrated, 'generic' care practices. It also provided the opportunity to 'free' up registrant's time to work with more advanced aspects of care provision, through focusing their attention on more clinically complex care and skilled therapeutic interventions, whilst also having an expectation of overseeing, and supervising the Associate when on shift. The second element of our report considered aspects of workforce strategy and planning in terms of offering a widening participation agenda to routes into health and social care careers. Providing both a funded (employer supported) and direct entry (self-funded) training route to become a registered practitioner, the associate roles into health and social care were a career potential and retention strategy for organisations seeking to employ and retain their local people (Hardy et al, 2023).

Anecdotally, during the recent months of public sector workforce industrial action, where patients were exposed to consultant practitioners early on in their assessment process, these people were less likely to be held up and hospitalised, but were efficiently referred on, or diagnosed promptly to achieve and access treatment pathways in a timely manner. There has been emphasis on achieving the UK Governments target for 50,000 nursing recruits, through a targeted international recruitment drive, yet much of this achievement is being offset by a high level of sickness, absence, staff turnover, and a mass of resignations, as health and care staff are choosing to work outside of their chosen professional career.

WHAT CAN BE DONE?

What is required therefore, is a more robust means of capturing and sharing data on the health and care workforce, one that can incorporate not just local variations, but address workforce trends on an international scale. By looking at workforce migratory patterns, where we see how many of our UK trained personnel often take some time to gather work experience overseas, but do inevitably return to home shores, and take up lengthy careers in

[21] https://www.gov.uk/government/news/government-sets-out-next-steps-to-support-social-care (accessed 11.5.2023)

[22] https://nhsproviders.org/news-blogs/news/nhs-providers-responds-to-social-care-workforce-funding-cut

our region, as their families grow and settle into their chosen locality. This level of longer-term strategic planning has, to date, been largely overlooked and under-estimated.

Any opportunity for aligning workforce data, exposing this to critical peer review and moving to a more co-ordinated approach has the potential for improved understanding around the complexity of trends occurring over time. Plus, the potential for improving data accuracy importantly across both health and care settings and therefore scope to achieve horizon scanning and predictions, associated with workforce requirements and inbuilt flexibility to address and respond to changing global health trends and crisis (as seen with the COVID-19 pandemic).

According to Bourgeault et al, (2023) the pandemic has also exposed the need to explore details in terms of our workforce patterns, including a requirement to consider the value placed on many of our care worker across the continuum. For example, through exploring who counts as health and care workers, when in many countries care work is identified as domestic, and is being deskilled, and de-professionalised, therefore falling below some of the reporting mechanisms being established in international labour agreements and visa processing.

Another important element of working from an international workforce perspective is the ethical and moral codes applied to staff migration, particularly when high numbers of international recruits are being sought, sometimes from countries that themselves require investment in their own health and care workforce requirements, and associated impact on population health and economic status. What we aim to achieve then is highly ambitious in achieving an integrated approach to both health and care datasets we capture across Integrated Care Systems, pooling this data, and exploring it in more detail. Active participation in achieving this is underway, and we hope soon to bring news of establishing our new Workforce Intelligence Network.

Work is already underway exploring mental health and midwifery curriculums in other coastal communities around the world, exploring where and how mutual exchange can be achieved to maximise the skills and knowledge requirements to really effect an improved patient experience. We are examining effective retention strategies, and evaluating wellbeing initiatives locally, to further evidence what works, for whom, and how these activities can then be used at scale across different organisations and settings.

IN SUMMARY

Whilst NICHE is funded for a period to initiate work to achieve fully integrated care and sustainable systems of effectiveness, our intention is always to identify priorities that can make a real difference to our workforce, people, and the communities we serve. Aligning our work to the Norfolk and Waveney ICS goals of living and working well in our region, is something we can all do when working in collaboration.

The recent Hewitt report, (published 4 April 2023), recommendations that focus on change, collaboration and autonomy for, ‘unlocking the potential of our workforce’ (pg 64). We need to consider what are the new roles required to achieve coordinated integrated

neighbourhood care teams, who can really deliver on the right care, given at the right time, in the right place, fully wrapped around the person, in their local community, enabling them to live as independently, as possible. Hewitt (2023) recommends investment in the workforce development needs should be a long-term endeavour, based on a minimum 3 year rolling planning cycle. How we achieve this integrated workforce planning process, to address the widening gap that has been further exposed due to COVID-19 pandemic, requires commitment and collaborative expertise from those with the vision, who can translate that vision into a reality underpinned by the creativity to contribute valuable insights in shaping our workforce planning activities. How this workforce intelligence is then adopted into policy making is another potential gap, that needs to close, rather than be fuelled by fiscal arguments that there is not any more funding or investment available (Amanatidou, et al, 2012).

What we haven't discussed yet, are the working conditions our health and care staff experience. We will aim to cover some of this in more detail in future blogs, as the work of NICHE continues to unfold.

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Other useful resources on workforce

https://www.health.org.uk/publications/reports/falling-short-the-nhs-workforce-challenge
https://www.kingsfund.org.uk/publications/health-care-workforce-england

10. Rethinking Prevention: Supporting Healthier Choices in Coastal Communities for Lasting Impact

By Dr Sarah Flindall, GP Partner East Norfolk Medical Practice, Safeguarding and Audit Lead East Norfolk Medical Practice, Great Yarmouth and Coastal PCN Mental Health and Social Prescribing Lead
October 2024

Introduction

As healthcare professionals, we often focus on treating illness, but what if the key to better health lies beyond the GP surgery? At East Norfolk Medical Practice in Great Yarmouth, we're exploring a different approach—one that centres around empowering people to make healthier choices for themselves and their families. Rather than prescribing solutions, we're working with communities to help them take charge of their health by addressing the social factors that influence it. This blog shares how this approach is making a difference and where we hope it will lead.

Why Focus on Empowering Choices?

We know that health isn't just about genetics or access to medical care. As highlighted in much of the research we draw on, health is shaped by both nature and nurture. From early childhood experiences, like access to safe spaces for play, to later challenges such as unemployment or housing instability, our environment plays a huge role in shaping the choices we make. In coastal communities like Great Yarmouth, many people face barriers that

limit their ability to make healthy choices—whether that's a lack of mental health support, social isolation, or economic pressures.

But our focus isn't just on identifying those barriers. It's about helping people overcome them by providing practical, non-judgmental support that empowers them to take control of their health. We don't believe in simply telling people what to do or labelling their struggles as "bad choices." Instead, we recognize that every decision is shaped by a wider set of circumstances, and we aim to equip individuals with the mindset and knowledge they need to make informed, sustainable changes in their lives.

How Does It Work?

At our practice, GP trainees and I dedicate time each week to community outreach. We meet people where they are, particularly those who might be disconnected from health services or overwhelmed by their circumstances. We know that healthy choices don't happen in isolation—so we work with patients to address the broader social and environmental factors affecting their health.

We collaborate with local charities, housing associations, mental health organizations, and addiction support groups. Through these partnerships, patients are connected to resources that go beyond medical care, such as counselling, housing advice, and support for managing stress. These resources help create the space and stability that people need to make healthier decisions, whether it's adopting better eating habits or addressing smoking and addiction issues.

We've found that when people are empowered to make small, manageable changes, they are more likely to sustain them. This can lead to long-term improvements in chronic conditions and mental health, and a reduced need for emergency services (which are costly). It's a collaborative, ongoing process that focuses on choice, not prescription.

Recognizing That Change Takes Time

One of the key lessons we've learned is that healthy choices can't be forced. We understand that many patients come from backgrounds where adverse childhood events or economic pressures have deeply shaped their relationship with health. For example, we often encounter patients who have struggled with issues like obesity, smoking, or mental health for much of their lives, and change doesn't happen overnight.

We take a supportive, non-blaming approach, recognizing that choices like quitting smoking or adopting healthier eating habits are harder when people face significant stress or financial hardship. Instead of expecting instant results, we encourage small steps and acknowledge every bit of progress. By offering ongoing support, we help individuals build the confidence and resilience they need to make healthier choices, without feeling judged or blamed for their past.

The Challenges We Face

Of course, challenges remain. Maintaining engagement with patients who miss appointments or feel overwhelmed can be difficult, especially in mental health services. We've worked to

address this by making our services more flexible and patient-centred, ensuring that appointments are tailored to the individual's needs and circumstances. We also strive to keep our focus on long-term empowerment, rather than short-term solutions.
Another challenge is funding. Ensuring that these programs have the resources to continue is essential for their long-term success. We are actively looking for ways to secure sustainable funding to support this work, recognizing that these community-based interventions are as crucial as medical treatment in promoting health.

What's Next?
Going forward, our focus will remain on empowering people to make their own choices when it comes to their health. We're also looking at scaling up our efforts and collaborating with research institutions to build a stronger evidence base, so we can better understand the long-term effects of this empowerment-based approach.
We believe that by continuing to work closely with the community, we can help break down the barriers that prevent people from living healthier lives. It's not just about medical advice; it's about supporting people in discovering their own paths to better health.

Conclusion
At the heart of our work is the belief that empowerment leads to better health outcomes. We're not here to prescribe or dictate; we're here to support, guide, and encourage. By focusing on the social determinants of health and working alongside our patients, we aim to help people in coastal communities like Great Yarmouth make choices that work for them. It's a slow process, but we're committed to making a lasting difference, one small choice at a time.

11. Can you Reach? What you need, where you need it

BY RYAN HOWES, RN BANK NURSE
OCTOBER 2025

This Blog presents a quality improvement project inspired by both personal and professional experience. It has grown from my own experience both as a Registered Nurse and Son. The '*Can You Reach*' project grew from my own experiences and aims to ensure that all patients being cared for in a hospital setting can reliably access items required to meet their essential care needs whilst in hospital. By identifying and addressing barriers to essential care, this project demonstrates how a small, low-cost intervention linked to our own values and actions in practice can have a significantly meaningful impact on patient outcomes and experiences.

Essential care forms the bedrock of professional practice, yet a number of high-profile reports continue to highlight where these needs are not being met. One well-documented example is hydration: dehydration is associated with poorer outcomes, yet it is estimated that up to 45% of hospital inpatients develop it during admission (Shells et al 2018). Furthermore a 2015 study by Johnston et al (2015) found:

- 42% of patients could not reach their jug of water at the time of interview.
- 31% of patients found the simple task of pouring a glass of water difficult, very difficult, or impossible.

The consequences of dehydration are significant. Patients who develop it while in hospital experience longer admissions, higher rates of catheter-associated urinary tract infection, and increased mortality (Pash et al 2014). These outcomes not only impact patients directly but also place substantial financial costs on the care organisation.

Concerns about essential care are not new. In 2001, the Department of Health published the *Essence of Care: Patient-focused Benchmarking for Health Care Practitioners* (DoH 2001). This seminal document set out benchmarks for fundamental aspects of care, including food and drink, personal hygiene, privacy and dignity, and safety. The aim was to ensure that all patients, regardless of setting, could expect consistent standards in meeting their most fundamental needs. More than two decades later, however, many of the same challenges remain. Issues like hydration and call bell access, which were identified at the time as critical to patient safety and dignity, continue to appear in recent audits and reports (El-Sharkawy 2015).

These persistent gaps are not due to a lack of knowledge or awareness. Evidence from UK hospitals suggests that systemic barriers (including high staff turnover, insufficient staffing (Vindrola-Padros et al 2021) and excessive workload (Health and Social Care Committee 2021) impede the sustained implementation of quality improvement initiatives. Staff shortages and high turnover disrupt continuity of care, while heavy workloads reduce the time available for staff to attend to essential care needs.

In the NHS, it is routine to provide patients with a jug and cup of water upon admission. However, a critical step is often missed: ensuring that patients can actually reach their drinks. Literature suggests that accessibility itself is one of the main barriers to hydration (Davidson et al 2020).

Hydration is only one example. Patients may also need timely assistance with repositioning, pain relief, or using the toilet. All off which are essential care needs that require staff support. If a person cannot reach their call bell, they have no way of alerting staff when these needs arise. Although a call bell may appear "close by," it can easily be placed just beyond a patient's limited range of movement. This is not only a source of frustration but also a risk to patient safety.

A study by Capo-Lugo et al. (2020) confirmed that non-ambulatory patients are more reliant on call bells than those who can move independently. This issue is further magnified for patients in side rooms, whether for infection control, clinical reasons, or simply due to ward design. Without reliable access to a call bell, patients cannot alert staff to emergencies, pain, or essential care needs. The Royal College of Physicians highlights that call bell access is one of the key steps in preventing inpatient falls (RCoP 2021).

MY OWN EXPERIENCE

In early 2024 my dad developed the rare neurological syndrome Guillain-Barré. This acute illness progresses rapidly from numbness and tingling in the hands and feet to near total paralysis in a matter of days. He was rushed into hospital and was quickly admitted to critical care. Within the space of six days he went from being a fully independent and healthy 63-year-old to being completely bed-bound requiring full nursing care for all of his activities of daily living. Thanks to the expert treatment he received while in hospital, he survived and made an excellent recovery.

Once the acute phase of his illness had passed, he faced months of specialist neurological rehabilitation to rebuild the muscles needed for even the most fundamental tasks. Initially, something as simple as lifting a cup of water to his lips was impossible. During this time I visited him every day to help with his care. This was when I noticed a problem. More often than not, when I arrived on the ward, I found his bed space completely unsuitable for a person with his needs. His drinking water bottle would often be empty while his water jug remained full. His call bell was frequently lost under his sheets or draped over the oxygen tap behind his bed. His table was regularly placed out of reach, and his glasses were buried in the general clutter that typically gathers on patient tables. In short, in spite of having only very basic motor function, his bed space served to disable him even further.

After a couple of weeks, he regained the ability to drink independently, but only if the conditions were exactly right. He needed a sports bottle with a built-in straw, positioned at the very edge of his table. The table itself had to be pulled in close, as his range of movement was still severely limited. He also relied on someone else to ensure his bottle was filled. Unless these precise conditions were met, he was unable to drink independently. On more than one occasion I noticed that, because his bottle was left out of reach, he was becoming dehydrated.

UNDERSTANDING THE ISSUE

To assess whether this was an isolated problem or part of a wider pattern, I worked with the Quality Improvement team at the hospital where he was being cared for. We collected data through a survey of 168 patients across all adult inpatient wards (6 patients per ward across 28 wards). Inclusion criteria required that patients were either nursed in bed or required the assistance of two members of staff to complete activities of daily living. This ensured that the experiences of the hospital's most vulnerable patients were captured. Patients were excluded if they were fully independent, required only minimal assistance, lacked the capacity to consent, or withheld consent.

The survey was divided into two sections. The first section, *Patient Questions*, was conducted directly with patients to understand their personal experiences. The second section, *Visual Observations*, assessed the patient's immediate environment to identify any discrepancies between patient perceptions and observed reality at the time of the interview.

Findings revealed that:

- 1 in 3 patients reported not always being able to reach their call bell or bedside table when needed it.
- 1 in 4 patients stated they were consistently unable to reach their meals or essential items such as glasses, hearing aids, and mobile phones.
- 1 in 4 patients reported difficulty reaching a drink when needed it; however, visual observations at the time of interview indicated that in fact 1 in 3 patients were unable to reach a drink.

THE WIDER PROBLEM

I observed that these issues persisted throughout my dad's admission. Numerous members of staff interacted with him daily, but very few appeared to be aware of how a small, simple intervention could dramatically improve his safety and independence. This is not a problem confined to one hospital. Throughout my time as a nurse working on wards in the UK and Australia, I have seen the same pattern across many organisations. In our constantly busy ward environments, the essentials of care are too often overlooked. Under pressure, staff adopt a task-oriented style of working, where meeting the needs of patients can become a list of jobs to complete rather than people to be cared for.

The result is that patients 'essential needs (hydration, comfort, safety, dignity) are missed, with significant negative impacts on recovery and wellbeing. Behind every bed number is an individual. The importance of seeing the person, not just another patient in a hospital bed, cannot be overstated. Embedding these essentials into an effective workplace culture (Cardiff et al 2020) is key so that they are no longer occasional good practice, but the everyday norms of 'how things are done around here' (Drennan 1992).

INTERVENTION

From my experience and learning the proposed intervention is simple. During every patient interaction, and before leaving the bedside, all members of staff (from consultants to cleaners) are encouraged to ask: **"Can you reach?"**

This short question prompts both staff and patients to check the bed space and correct any issues. Examples might include:

- Moving the call bell closer and making sure the patient knows where it is.
- Filling a cup of water from the jug and placing it within reach.
- Passing the patient their glasses, hearing aids, or dentures.
- Positioning the table so it is accessible.
- Ensuring food items are within reach.
- Passing personal items such as a phone, book, or newspaper.

These small interventions can significantly improve patient safety, experience, and outcomes while costing staff only a few extra seconds. The key objective is simple:

"Set patients up to be left safely and successfully"

By ensuring all essential items are within reach, staff free up time, empower patients to remain as independent as possible, and reduce unnecessary risks. A 2022 study has show that ensuring call bell access and proactive staff engagement reduces inpatient falls by 20–30%.

CONCLUSION

Its simplicity and minimal financial burden make "*Can You Reach?"* an easily scalable solution across all health and care settings, costing staff only a few extra seconds of their time. To achieve its full potential, however, it requires a consistent approach to developing care and commitment from all staff groups who have face-to-face interactions with patients. Widespread communication and cultural buy-in in the workplace are essential to ensure adoption and embedded sustainability.

It is also crucial to recognise the systemic barriers that have historically prevented the sustained implementation of essential care interventions in UK hospitals (high staff turnover, insufficient staffing, excessive workload). Without addressing these challenges, even simple, evidence-based interventions risk being overlooked or inconsistently applied.

By embedding *"Can You Reach?"* into core staff training and everyday practice, and coupling it with organisational support and broader culture change, health and care organisations can begin to overcome these barriers. This approach helps refocus attention on the essentials of care and fosters an environment in which the needs of the person are consistently kept at the forefront.

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Acknowledgements

I would like to thank the staff and patients at the Norfolk and Norwich University Trust for their participation and support in this project. Special thanks to the Quality Improvement team for their guidance in survey design and data collection. I am also grateful to colleagues and mentors: Suzanne Nurse, Jonathan Webster, Debbie Cubitt, and Steve Smith who

provided valuable feedback and insight during the development of this project and the writing of this Blog. A special thanks also to my Dad, Keith

12. Feeding it Forward, Co-Supervision as a Healthy Conversation

By Dr Sally Hardy, Professor of Mental Health and Practice Innovation and Director of NICHE.
In conversation with Paul Johnson, Group Analytic Psychotherapist, Psychotherapist, It Starts With Us
January 2024

Introduction

Thinking about what a new year will bring can often be a daunting prospect. We all face challenges, some of which are known, others remain unknown, in what another year entails. Whether a challenge this year is to change, in terms of career, lifestyle, or behaviour changes, we know that human behaviour is frequently inhibited by past experiences, manifest most comfortably by repeat patterns, or relying on old habits we have formed over many years to manage anxiety and stress. For example, when considering work pressures, we know our public services are challenging places to work and can also be challenging for those receiving services.

As those ambitious New Year resolutions begin to fall by the wayside, it is our old habits that quickly start to resurface. This blog explores how to utilise aspirations in terms of 'feeding it forward', and how important time spent in conversation with a critical friend can become an essential arsenal in our armoury, from which to remain buoyant in the relentless challenges,

and anticipated changes we will undoubtedly experience in our working and home lives. Importantly, how can we keep ourselves vibrant and excited as to what is around the corner?

Captured in this blog is the essence of a critical conversation between a colleague and myself, whom many of you may know. Paul Johnson worked for over 21 years in our Norfolk and Waveney System, most recently at Norfolk and Suffolk Mental Health NHS Foundation Trust (NSFT), as their lead educator. Paul and I worked together for several years, culminating in working with Sri Lanka to extend mental health knowledge and skills through the NHS England funded mental health programme.

Our critical conversation occurred in early January 2024 aiming to use that precious time before starting back at work post winter break. We wanted to have some time to share both recent life events and work-related issues, gaining insights from each other's knowledge and expertise as a process of co-supervision.

WHAT DO WE MEAN BY CO-SUPERVISION?

Co-supervision, in this context, is a collaborative inquiry approach where supervision is a conversation between two people who agree to take turns in discussing aspects on which to critically reflect. A mutual goal is seeking a shared understanding and enhanced learning potentials from the issues being discussed. Through drawing upon each other's expertise, theoretical perspectives and experiences, co-supervision provides a safe space to explore aspects we find challenging. Also known in the therapeutic field as peer supervision, (Basa, 2019), this approach offers an alternative to more formal approaches to clinical, or managerial supervision, where there is an anticipated level of hierarchical standing between a learner and their more experienced or skilled supervisor. Working in this mutually respectful dyad (or pair) provides a reflective space and time given to reaching a deeper understanding of situations, motivations and informed actions, as a mutual endeavour for supporting and further stimulating each other's work. However, in our discussion we also realised we were keen to feed forward our learnings, in the process of further enabling others in their situations and circumstances.

Hence the idea of writing up our conversation into a blog. We share this blog, not only as an example of how to address and capture contemporary workplace challenges, explored from a psycho-dynamic perspective, but also in how to keep our personal inner selves from the potential risk of drowning under the pressure of workplace demands during 2024 and all it has to offer and will bring for us to deal with.

Sally: How is the new job going?
Paul: I am getting into the rhythm of it, although still early days and having to get used to all the travelling and being away from home. Having been over 22 years in the NHS it is hard to not feel constantly guilty for not working in the same way I did in my previous role. With the commute to and from London it gives me time to listen to podcasts, and think about the programme I will be delivering & ruminating on the culture of the organisations I work with. Then the return journey is about reflecting on what worked well, what could be improved, why did this happen, what else can I share with the delegates next time?

Sally: It is fascinating, isn't it, that our brains need to process complexity that way. It is as if our backgrounds in mental health and your group psychotherapy training helps us achieve that processing quite quickly. Being able to quickly read the room, understand the dynamics of a team or an organisation and the working relationships within it, are so important.
Paul: Definitely. I see so much shame in the system. Where people are feeling under the gaze of auditors, Care Quality Commission (CQC), regulators, whatever it is, there is a constant fear held that people are not performing somehow. And even wider than that organisations are also facing shame. All of which has an impact on the staff who work within it, have to hold that feeling and sense of being overlooked and judged all the time. It can become traumatising for the whole system.

Sally: That article you shared with me before, on Fear and Anxiety in Healthcare – who was it again?
Paul: Ah yes – Ben Fuchs. Ben and I talked about Shame in healthcare, and he shared his paper and ideas, which was pre-pandemic but highly relevant to today.

Sally: It is as if Freud's iceberg analogy, of what is happening underneath the surface, in our subconscious is the guilt and shame and this manifests itself above the water, as behaviours, where people are either angry or resistant to change, and seeking blame elsewhere. It becomes that victim cycle where people feel trapped and ineffective.
Paul: Yet how do we enable people to address that through the work we do? The company I work for 'A Kind Life', recognises the need to facilitate and enable others through our programmes of work, but how to sustain that level of awareness is difficult longer term. We can address the individual, but the system level has an impact of re-traumatising staff and causing them to repeatedly experience shame, fear and anxiety.

Sally: I think that is where our facilitative work comes in, at that level of exposure. Yet, how to achieve that in a non-threatening way, in not being seen as someone coming in to yet give more pressure and pile on more shame. I see so often in the work I do that people are suspicious of how I want to work in collaboration with them, and their organisation, as their own expectation can be that we are in competition with them somehow, or being brought in to make change, when real transformational change happens from the ground up, and when board to beside there is a shared vision and value base for improvement.
Paul: What do you do then to build relationships with people? How do we allow them to feel safe enough to start to challenge their conventional thinking and long held traditional ways of doing things, having people come and do to them, rather than working with others?

Sally: I think I have to role model being accessible, non-threatening, create a safe space for having critical conversations, like we are doing now. But that can take time and a mutual understanding of how to attain a shared vision for change. It's about trying all the time to walk alongside people. If you can get like-minded people together, with an articulated shared vision and shared values that is when magic starts to happen.
Paul: Then life throws a curve ball, like a bereavement or something and it can destabilise that. We don't live life in a vacuum and have to pay equal attention to home and well as work.

Sally: For sure, it took me a while to realise I got terse with my family after my mum died. I was missing her I guess and that spilled over into my working relationships a bit too, as I got more and more intolerant of people, as if no one else had ever felt bereaved! We just don't get the space to talk that through with colleagues, perhaps for fear of making them, or me cry, or showing vulnerabilities in the workplace.
Paul: Families are such an important primary learning though. As the youngest of seven I found I needed to use all my project management skills for my Dad's funeral.

Sally: We are getting older Paul, losing our parents. It makes me think of my own mortality, does it you?
Paul: That's why I want to continue to feed it forward, sharing with the next generation, sharing my knowledge with others in the work I do. How can I do more of that in 2024?

Sally: That's a great idea, and something I am using in a talk that's coming up with the Embedded Scholars discussing 'what is next?'. How do they ensure they are also mentoring, coaching and bringing on others? It is important aspect of collaborative learning, no matter where people are in their career. There is a book by Richard Rohr called 'Falling Upwards', where he talks about how we spend so much time and energy climbing the career ladder, do we give enough time to considering what do we do when we get to the top? Where do we go then? Do we spend as much time planning for latter life, and how we use these life events to enable others on their life journey, sharing our wisdoms and experiences?
Paul: I did a podcast for Verve Health Care the other day on workplace kindness, culture and leadership[23], which covered some of that - I will share it with you

Sally: Can I get permission to use it in the NICHE newsletter, or website, for others? A great example again of us feeding forward.
Paul: Yes of course, this is all part of my feeding it forwards. I will check but I am sure it is freely available.

SUMMARY

Even within this brief extract of what was a far longer, involved and personal discussion between colleagues, we hope that what becomes clear is how a critical conversation allows for shared learning. It is recognised that such a conversation has beneficial outcomes. Not just for building our confidence, as ideas and thoughts are verified by another person, in agreement that we are doing the right things, but also in the shared ambitions and career goals of giving back. Giving back is one of the five steps to wellbeing[24]. By making these social connections, giving time to each other in a critical conversation serves to reduce isolation and put a measure on self-doubt, as ideas and concepts become clearer in discussion with others. All of which are part of a healthy engagement and helps in achieving living fulfilling lives, in a fast-paced, charged and challenging world within which we inhabit together. Remaining open,

[23] With kind permission. Podcast link to Paul speaking on 'Kindness in leadership: Unlocking Workplace Wellbeing' can be found here: https://youtu.be/0j919r3C-r0?si=jpFL_jGrTJ0k6MHp.

[24] 5 steps to mental wellbeing https://www.nhs.uk/mental-health/self-help/guides-tools-and-activities/fivesteps-to-mental-wellbeing/ (last accessed 17.1.2024)

curious and having mutual respect for each other's experiences is a worthy professional and personal investment. Try it sometime soon. We think you will enjoy the experience.

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13. Thinking Back and Looking Forward – Leading with Authenticity and Integrity in a Complex World

By Dr Jonathan Webster, Professor of Practice Development & Co-Director NICHE
July 2025

Many of us over our careers will have had leadership roles and experienced the 'outstanding, the good, the bad and the ugly' of leadership. My experience of outstanding leaders are those people who have nurtured me as an individual and as a member of a team; they have helped me to grow professionally; they have used every opportunity to help me learn by reflecting on my successes and challenges, recognising that learning in the workplace and academic study is key to development. Such leaders have created a workplace culture that see's 'me' as a 'person', they have ignited a curiosity in the workplace setting in which all can grow and thrive. They have also displayed the characteristics of tenacity and a willingness to 'challenge' and to hold self and others to account for their actions and behaviours, they have been prepared to put their head above the parapet and to ask the unpopular (non-group think) question because it was the right thing to do. Such leaders don't display characteristics of egotism, it's the team and others first each and every time – every opportunity is used to celebrate the team's success, not theirs. These characteristics and behaviours strike me as being key, to the ability to lead with authenticity and integrity.

At this current time, within the 10 Year Plan for Health there is a key focus on the importance of supporting leaders aimed at improving culture, capacity and care delivery (The Kings Fund 2025). We have heard a lot about the importance of leadership over the years and a significant investment in helping people to become the leaders of both the here and now and for the future. And yet, stories (and lived experiences) still resonate of poor experiences of leadership at all levels. In a world that often celebrates charisma, quick wins and image-driven success, authentic leadership offers an important and increasingly necessary values driven approach to support development and transformation. At times of turmoil, uncertainty and change it's not about being the loudest voice in the room or saying what others want to hear. It's about being 'real' and grounded with people and communities at the heart of decision making – it's about being authentic to self and others.

But what does it actually mean to be an authentic leader - is it just about 'being yourself', or does it require something deeper, more intentional? At its core, authentic leadership is a leadership style built on the foundation of self-awareness, transparency, ethics, and inclusivity. Popularized by leadership experts like Bill George, former Medtronic CEO and author of '*Authentic Leadership'*, the concept emphasizes leading with your true self—your values, your beliefs, your story.

Authentic leaders are not perfect. They're human and in being human share when 'things' haven't gone the way that they had planned and share their learning to inform their own (and others) growth and development. They lead with purpose, they know who they are and they

don't try to be someone else to gain approval or maintain power. They build trust through openness and consistency rather than control or manipulation personal ego has no place in their approach.

There are four key components that are widely accepted as the pillars of authentic leadership:

1. **Self-Awareness.** This is the foundation. Authentic leaders understand their strengths, weaknesses, and emotions. They reflect regularly and seek feedback—not just to appear humble, but because they genuinely want to grow and learn with and from others.
2. **Relational Transparency.** They don't hide behind corporate speak or the power of their position or title. They're open and honest in their communications, even when it's uncomfortable to hear what others might say.
3. **Balanced Processing.** They listen to different perspectives before making decisions. They don't surround themselves with 'yes-people' or dismiss/ belittle different opinions – they see alternative views as a positive force to both critique and to build a consensus to move forward with. Authentic leaders are willing to change course when evidence and values require it and are prepared to listen and welcome the voice and views of others.
4. **Internalized Moral Perspective.** Perhaps most importantly, their actions are guided by a strong, inclusive ethical compass. They don't bend their principles to chase popularity, power or short-term gains to benefit themselves or to please 'others'.

Why Authentic Leadership Matters More Than Ever

High profile reports into the failings of care have brought to the fore the importance of leadership. Top-down, command-and-control (high octane) style leadership approaches have a place when immediate action needs to be taken, but is not the solution for organisations and systems that wish to transform and sustain ongoing development and growth. Invariably these (top-down etc) leadership styles do not have at their core Collaboration, Inclusion and Participation (CIP) of all stakeholders (internal and external), which is a central feature to help shape growth, development and embed sustainability in the workplace culture where all can thrive.

In all environments, authentic leaders stand out because they:

- **Build lasting trust**. Trust isn't a given - it has to be earned not by a title or position but by what they do and how that is experienced by others. Authentic leaders earn trust by visibly doing what they say and saying what they mean.
- **Foster inclusive, safe and effective workplace cultures that are good places to work**. People are more willing to contribute and innovate in environments where they feel seen, valued and heard (Cardiff et al 2020).
- **Navigate uncertainty**. When difficult times occur, people want leaders who are honest about challenges, ethical in their actions and steadfast in their values of authenticity and integrity.

- **Attract and retain talented people**. People who strive to make a positive change are drawn to leaders who live their values and who demonstrate authenticity and integrity in how they act and respond.

Authenticity doesn't mean a person never adapts, evolves, or reflect on their behaviour. It means they evolve **from a place of integrity**. Being authentic doesn't give a person a license to be reactive, inconsiderate, or resistant to feedback. True authenticity requires deep inner work. It's about aligning actions with personal values, and those values must be examined and refined over time based on learning with and from others. Becoming an authentic leader is about a willingness to embrace embedded learning, recognising that this will never end. It's about looking a person in the eye and knowing that the decision you made, no matter how hard, was the right one driven by authenticity and integrity.

So what does this all mean? Its over 20 years since Bill George wrote about 'Authentic Leadership'. We live and breath the complexities and challenges of day- to- day life in systems that are under pressure, constantly changing and are financially challenged. What becomes clear is that the 'same old' transactional approaches to leadership i.e.
'doing to' rather than 'leading with' will not deliver the sustained, embedded transformation needed for both the here and now and for the future which is rightly expected by all.

As Bill George wrote, '*You can only lead others if you can lead yourself*'. Leading with authenticity and integrity starts with that choice a leader makes — to lead, not from personal ego, a position of power, title or image perspective. Simply, the values they hold both professionally and personally as a person grounded in openness, transparency, ongoing learning and inclusive ethical actions.

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14. What The World Needs Now is…….

By Ann Jackson
September 2025
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It's not often in a career that we get the opportunity to write completely freely and informally; this is that chance for me. In this short piece, I want to share a personal and a professional journey – one in which I have become engaged with the social movement of compassion and the specifics of self-compassion. I have come to believe deeply in the potential for compassionate approaches to life, nursing and leadership to nourish us in a world which sometimes feels devoid of anything that feels like empathy or compassion. I have written elsewhere that to choose a compassionate way to work and to lead is a political act (Jackson 2025) – by this I mean that we can engage with activism as a way of living and working, that is inspired by the definition of compassion as offered by Paul Gilbert "*a sensitivity to the suffering of others and self with a commitment to prevent and alleviate it*" (Gilbert 2009). Having spent over 40 years in mental health nursing, I have worked intentionally to uphold a strong value-base of equity and equality, have actively supported policy and practice that is both evidence-based and at the same time, provides a strong foundation for meaning, purpose and authenticity.

We now live in a political arena that no longer serves us with a moral purpose or a shared sense of belonging, nurturing and loving kindness – it can feel cruel, isolating and de-humanising. The power of this can seep into the way we feel about our own lives, our work and our relationships – if we let it. One thing I wish I had known many years ago and had been taught – is how to manage and soothe my nervous system. Now I feel that we should share this well-established knowledge in our teams and organisations – that anxiety, uncertainty,

criticism and system failure provides the complex contexts for staff to be chronically stressed, feel overwhelmed, burnt out and sick…sick in our hearts and sometimes, sick to our stomachs….

What is the consequences of this? I believe there is a diminishing capacity for creativity, trust, learning and connection and I also believe that whilst compassionate leadership, as described by Michael West (2021), provides the healthcare system with the architecture to curate this, there is a responsibility on us all as individuals to support a compassionate approach to our work. We can do this relatively easily by developing 'compassionate flow' – compassion we feel for others, compassion we can receive and compassion we offer to ourselves. In this way becoming more aware of the flow around us and between us, developing attunement for the suffering of ourselves and our colleagues and at the same time taking steps to notice, understand, empathise and take action. Kristin Neff (2021) has described this 'action' part as 'fierce self-compassion' - to protect from harm, provide for ourselves and motivate us into activism. I was reminded recently of the need to draw from our own examples when we are attempting to teach or coach others in this. There have been many examples along the way, but for me the most compelling was in 2002 when I led the development of the RCN's women's mental health group; spurred on by bearing witness to the paucity of gendered knowledge, policy and practice in mental health and beginning to appreciate that any attempt to wait for someone else to do it was seriously flawed! I became increasingly aware of my own responsibility to use the role I was in and the platform I had, made my step into leadership a 'must'. I later came to appreciate the courage in this and have never regretted stepping into a space that was unfamiliar, uncomfortable and sometimes lonely. Now I often observe the same in others – the deep desire to change or challenge the status quo but with a hesitancy to stand out and speak up. Whilst there is almost always nobility in the intention, there is often fear holding the person back. It is a privilege to support leaders take that first, second and many more steps – the path, as we know, is only paved as we walk it……

And yet, we work and live in times that are increasingly more stressful and thus, the need for good well-being and mental health is at a tipping point. In a post-covid climate where resources are scarce, workload pressures greater than ever, it is only a matter of time before we have a largely 'sick' workforce – overworked and under-supported. So, we remain in contradictory terrain – on the one hand we have a greater ease of language about our anxiety and depression, burnout and suicidality and on the other hand, we expect people to develop individual 'resilience' without sufficiently addressing the underlying organisational factors that contribute to the process of dis-ease.

As I write this, it is World Suicide Prevention Day and it is apposite to draw attention to existing initiatives to understand more about suicide in NHS healthcare staff , the support resources available to staff and specifically for female nurses, the Nurses Suicide Study, who are considered to be at 24% higher risk of suicide than the general population. Implementation of all these resources provide guidelines and policy to create a workplace culture that promotes mental well-being, encourages early intervention, and supports recovery following traumatic events. Both compassion for others and self-compassion are vital components in achieving workplaces that are psychologically safe, where there is openness and individuals can seek help when they are struggling with work-related stress. We really do need to look after

ourselves at a deep level as we work to be in service of others – our colleagues and our patients.

As we also have access to a greater knowledge and wisdom about our collective nervous system across the health sector, there is no excuse now for leaders at all levels to be aware of the effects of stress on the body, mind and brain. It is limited indeed, for leaders to ignore the warning signs…only this week I have heard words like 'savage' and 'brutal ' as descriptors of organisational change – it is hard to hear that after all these years, we really haven't come that far in practising what is preached – inclusive and compassionate cultures where psychologically safe teams embrace vulnerability as strength, where bringing your whole self to work is encouraged and where trust is upheld as the most important value in healthy, effective team-working and relationships.

As we accept our shared and common humanity, inherently flawed, we must endeavour try to connect authentically with people who are suffering, as are we. We are expected to do this in an imperfect system, society and world where vulnerability is yet to be seen as a strength, where inequalities persist and where national policy is uncertain. To make systemic change is to be part of a social movement of compassion, to participate in actions that can work towards the prevention of suffering and injustice.

Therefore, the healthcare workforce, educators and leaders need to have the curiosity to notice and name suffering around them, to have the complex skills and personal qualities to respond with compassion and have the courage to always act with integrity and wisdom. To work compassionately is a skill and a choice; perhaps more importantly, and to return to my beginning, it is a *political act*.

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15. Conclusion

By Dr Sally Hardy, Professor of Mental Health and Practice Innovation and Director of NICHE
November 2025

Engaging with health and care services whether as a porter, pharmacist, practitioner, patient, or professor, brings with it a complex mix of challenges and opportunities. These challenges often reflect the deep, nuanced realities of people's lives. When we seek to capture impact within this complexity, things become even more difficult to clearly define. Yet, reading through these blog entries reminds me of the core mission NICHE set out to achieve alongside our integrated care partners: to make Norfolk, Waveney, and Suffolk a great place to live and work. These blogs for me, capture and reflect that journey, as the narratives gathered from colleagues engaged in NICHE's work, who have generously shared their knowledge, expertise and insights with others, cascading the principles of high support with high challenge that enables personal growth and professional developments. These are stories of hope, transformation, and the power inherent in 'paying it forward'.

Whatever lies ahead, either professionally or personally, we hope these Blogs can inspire you. Be inspired to believe that change is possible. Inspired to create space for others. Inspired to build something meaningful, together with those who share your values and beliefs and can offer you eight minutes. When we collaborate with openness, empathy and a shared purpose, life becomes not only manageable but rich, fulfilling and worthy of living well.

OUR THANKS AND ACKNOWLEDGEMENTS TO:

The contributors to this publication and the NICHE Team – Jo Odell, Johnny Yuen, Joe Collins and Idris Phillips-Fry in the compilation of these monographs.