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Special Measures, Burnout And Occupational Stress In National Health Service Staff: Experiences, Interpretations And Evidence-Based Interventions.

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**Special Measures, Burnout And Occupational Stress In National
Health Service Staff: Experiences, Interpretations And Evidence-
Based Interventions.**

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North Wales Clinical Psychology Programme

Bangor University

June 2019

**This thesis is submitted in partial fulfilment of the regulations for the
Doctorate in Clinical Psychology**

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Section 1

Thesis abstract

This thesis explored two areas important to professionals working within the National Health Service (NHS): working under special measures, and interventions to manage occupational stress and burnout.

A systematic literature review with a narrative synthesis explored workplace interventions designed to reduce or prevent occupational stress or burnout for NHS staff. Eighteen studies met the inclusion criteria of the systematic search and were narratively reviewed. Three overarching categories of mixture of intervention types were identified which included nine studies examining ‘individual support’ interventions, four studies examining ‘individual support interventions’ and five studies looking at ‘organisational and team-based interventions’. The review identified a minimal number of interventions which significantly reduced or prevented burnout in NHS staff, with none evidencing long term effectiveness. Areas for further research into interventions are suggested and recommendations made for managing this within the unique context of the NHS.

The second paper shows the results of an empirical study, which utilised a qualitative approach to explore Inpatient Mental Health (IMH) nurses’ perspectives on how special measures has impacted on their experience of working in an organisation in special measures. The principles of Thematic Analysis (TA) directed the analysis of semi-structured interviews conducted with ten IMH nurses. The analysis produced a singular main theme showing the confusion of special measures process, which influenced the three key themes with related sub themes. Implications for clinical practice and future research are discussed.

The final paper examines the theoretical and clinical implications of the first two papers, as well as providing personal reflections of the main author’s experience of conducting this research.

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Section 2: Literature Review

*A Systematic Review with a Narrative Synthesis Of Workplace Interventions
Which Reduce Or Prevent Burnout And Occupational Stress In National
Health Service Employees.*

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Declaration of Conflicting Interests

The authors declare that there is no conflict of interests.

This paper will be submitted to The British Journal of Psychiatry and as such will follow submission guidelines for the journal: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/information/instructions-contributors#_Review

Abstract

Introductions: Research suggests that professionals working within healthcare organisations experience heightened level of occupational stress and burnout. However, there has been no published literature review in this area specific to NHS staff. Therefore, this systematic review with a narrative synthesis aimed to understand the workplace interventions designed to reduce or prevent occupational stress or burnout for NHS staff.

Methods: Searches of Medline, PsychINFO, Web of Science and CINAHL were conducted. Studies were included if published or cited between 1989 and 2018, were conducted on NHS staff, and contained interventions aimed at impacting occupational stress or burnout. Studies were excluded based on several criteria including being non-English.

Results: Eighteen studies met the inclusion criteria. A narrative synthesis by the author provided three overarching categories of intervention to describe the multiple interventions types used: ‘individual support interventions’ (nine studies), ‘training staff in therapy skills interventions’ (four studies), and ‘organisational and team-based interventions’ (five studies).

Conclusions: There are few interventions which significantly reduce or prevent occupational stress and burnout in NHS staff with limited evidence shown in any study of long-term effectiveness. Further research into these areas of limitation are suggested, also recognising the unique context of the NHS.

Keywords: *Burnout, mental health professionals, national health service, occupational stress, work-related stress.*

Introduction

Background.

Burnout and occupational stress can become a major issue not just in an individual's personal life but can also impact heavily on their working life. Occupational stress and burnout impact workers productivity through affecting their mental health and physical health leading to an impact on their ability to work. Ability to work is affected detrimentally by burnout as it affects an individual's ability to attend work, and their ability to be productive once they are at work (Nevanperä et al., 2016). The cost of occupational stress and burnout to the United Kingdom (UK) productivity alone is estimated annually to be anywhere in the region of £4.17 billion and £18.17 billion (Hassard, 2018).

Description of condition.

Chronic occupational stress can lead to workers having an inability to perform their jobs due to a reduced level of emotional, physical and psychological resources to manage and cope (Quick & Henderson, 2016). Consistent exposure to increased levels of occupational stress can lead to burnout (Maslach & Leiter, 2016). Burnout is not recognised as a distinct disorder according to the American Psychiatric Association (2013), but it is defined most consistently in the literature by Maslach, Schaufeli and Leiter (2001) as presenting symptomatically in three key areas; emotional exhaustion, depersonalisation and reduced levels of personal accomplishment. Emotional exhaustion is when an individual has been emotionally strained by their job role. Depersonalisation occurs when an individual feels disconnected from people around them, and reduced personal accomplishment is denoted by a drop in the occupational productivity via the culmination of both emotional exhaustion alongside the impact of depersonalisation.

Interventions and methods of implementation.

Stress management interventions in the workplace have been categorised into three separate groups in the literature (Günthner & Batra, 2012). The first group is those interventions classified as primary or stress reduction strategies which aim to change the working environment, thus mitigating any identified potential stressors. Secondary, or stress management strategies, include those interventions which aim to support individuals experiencing a stressful working environment to be able to cope and manage. Tertiary, or stress treatment strategies, aim to enable individuals to recover from the effects of experiencing stress or burnout from their work environment. All strategies can be further classified as either working with the individual, working with a group, or focusing on the organisation as a whole, with some primary, secondary and tertiary strategies utilising a combination of individual, group and organisational intervention strategies. The variety of interventions are shown in Table 1 (Schaufeli & Enzmann, 1998; Cottrell, 2001).

Table 1.

Occupational stress management interventions

	Primary <i>Stress reduction</i>	Secondary <i>Stress management</i>	Tertiary <i>Stress treatment</i>
Individual <i>individual perspective</i>	Personal stress profile feedback Time management Career guidance Assertiveness Communication skills Psychoeducation	Healthy Lifestyle Reflection Clinical supervision Mentorship Buddy systems Relaxation Home/work interface Support mapping Biofeedback Imagery	Counselling Psychotherapy Occupational health interventions Physical wellness Lifestyle work
Group <i>Team perspective</i>	Team building Team role analysis Boundary clarification	Group development Clinical team supervision Dependency/skill mix Workload analysis and review	Therapeutic remedial teamwork Work group role negotiation
Organisation <i>Systems perspective</i>	IPR PDR Job role clarification Employee empowerment schemes	Workload management Mission clarification Risk analysis and management Employee participation	therapeutic consultancy Re-organisation Transformation programmes Employee Assistance Programme Process re-design Cultural change work

Rational for the review.

Several large reviews have examined the literature surrounding interventions which have an impact on occupational stress and burnout within healthcare staff from around the world (Dreison et al. 2018; Johnson et al., 2018; Ruotsalainen et al., 2015), including specific groups such as mental health staff (Gilbody et al., 2006), or specific professions such as nurses (Galbraith & Brown, 2011).

Though there are several ways of operationalising workplace distress mentioned in the research (i.e. compassion fatigue (LeMaster & Zall, 1983)), occupational stress (Selye, 1956) and burnout (Freudenberger, 1974) have been defined and established in the literature for a long period of time and are still terms used today to explain workplace distress (Dyrbye, Shanafelt & West, 2019). The use of the established Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1986) has been a key factor in measuring burnout and its potential for increase and reduction through the use of interventions globally. Therefore, in order to

capture the maximum number of interventions which may impact on workplace distress, but also to help focus the reviews terminology, it was deemed searching for interventions which impact occupational stress and burnout would provide the highest yield of studies and therefore a more informative narrative around interventions.

Research suggests that the level of occupational stress and burnout experienced by staff who work within healthcare organisations is high due to several additional factors in comparison to more general occupational stress, as it includes unique time pressures, shift patterns, variability in workers available and level of work expected within these confines (Van Bogaert et al., 2013). Staff working within healthcare organisations experience additional aggression (Iozzino et al., 2015), and have to manage both highly distressed individuals dealing with complex long-term health conditions, and their families (Chambers et al., 2015). It is also noted the difficulty in conducting research on NHS staff due to lack of funding and time to allow staff to engage in the process, as well as lack of support from leadership (Marjanovic et al., 2019).

Though there have been recent reviews examining the interventions available for general healthcare staff, these have had wider focus examining studies across the world (Dreison et al., 2018; Johnson et al., 2018). These more general overviews have not considered the specific challenges that can arise when delivering an occupational stress and burnout reduction intervention in the NHS for staff. The NHS employs over 1.3 million staff across the UK who provide care for over 240 million patients every year (NHS Confederation, 2017). In order for the NHS to continue to provide a high level of care to this many service users, it is imperative that the wellbeing of staff members is seen as a priority. However, evidence suggests that comparatively, there are a larger number of absences in the NHS in comparison to both the private sector and the rest of the UK public sector (Chartered

Institute for Personnel Development (CIPD), 2013) thus suggesting this is not the case. This can have a negative effect on the quality of care due to reduced staff, but burnout and occupational stress can also inhibit an individual staff member's ability to provide high quality care thus reducing the quality of care to service users (Powell et al., 2014). This in extreme cases can potentially lead to the safety of service users being affected detrimentally if care is being delivered by occupationally stressed and burnt out staff (Wilkinson, 2015). Given the impact that occupational stress and burnout has both economically but also to staff and service users safety and wellbeing, it is important to identify interventions which can reduce this. Specifically, recognising the additional burden that appears to be on the NHS as one of the UK's largest employers, and the important role it has on keeping individuals in the country well and safe through high quality care, and thus productive, means recognising those effective workplace interventions for burnout and occupational stress in NHS staff is essential.

Aims of the review.

In order to develop the question for this systematic review with narrative synthesis, several question formulation frameworks were consulted (Polit & Beck, 2018). The framework selected was an adaptation of the PICO (Population, Intervention, Comparison, and Outcome) framework for developing review questions called PIO (Population, Intervention and Outcome) (Santos, Pimenta & Nobre, 2007). PICO and PIO were originally utilised to develop clinical questions for clinicians to help patients, with the framework now also adapted and utilised to aid formulation of literature review questions (Polit & Beck, 2018). PIO was selected as it was a better fit with the inclusion criteria of including all studies (including studies without a comparison group) which would allow for a wider range of papers to be considered. With regard to PIO, the 'Population' this review will examine is

NHS staff, the ‘Interventions’ will be occupational stress and burnout interventions, and the ‘Outcome’ will be measurement of occupational stress and burnout. How this PIO framework is applied to developing both the main question, and secondary questions asked of this review can be seen in Table 2.

Table 2.

PIO information in relation to questions.

<i>PIO</i>	<i>Label</i>	<i>Primary question</i>	<i>Secondary questions</i>
Population	NHS staff	What is the level of available evidence with regard to occupational stress and burnout interventions for NHS staff?	<ul style="list-style-type: none"> • What occupational stress and burnout interventions exists for NHS staff? • What does the current evidence suggest is most effective for managing occupational stress and burnout in NHS staff? • What are the specific NHS issues in delivering and researching occupational stress and burnout interventions to NHS staff?
Intervention	Occupational stress and burnout interventions		
Outcome	Measurement of occupational stress or burnout		

In providing an answer to these questions, this review aims to focus on:

- Systematically finding and reviewing studies examining workplace interventions which ameliorate or prevent occupational stress and burnout for staff working within the NHS.
- Identifying and reviewing the range of workplace interventions and their effectiveness, which ameliorate or prevent occupational stress and burnout for staff working within the NHS.
- Reviewing the quality of those studies identified and the effectiveness of the workplace interventions used.

- Clarifying whether there are NHS specific issues which impact on carrying out research surrounding workplace interventions which ameliorate or prevent occupational stress and burnout for staff working within the NHS.

Method

This review took the format of a systematic review with a narrative synthesis (Ryan & Cochrane Consumers and Communication Review Group, 2013). This was chosen for several reasons. Firstly, the systematic search offered a process of providing evidence through a rigorous and replicable method, while the narrative synthesis allowed the review to cover a range of types of study in order to answer the question. Also, a systematic review with a narrative synthesis allowed the results to answer the different areas of the question that was asked of the literature, and not just those relating to quantitative rating of effectiveness as per meta-analysis (Popay et al., 2006). Finally, a systematic review with a narrative synthesis is an established method of providing a text-based overview of several areas of the question asked (Popay et al., 2006). Initial searches for literature utilised the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) (Moher et al., 2009).

Definitions: Burnout and burnout workplace interventions.

Burnout is conceptualised by Maslach et al. (2001) as a work-related mental health difficulty which includes three elements: emotional exhaustion, depersonalisation and a lack of personal accomplishment. Burnout workplace interventions aim to promote recovery from high occupational stress levels or aim to have an ameliorating or preventative impact on occupational stress levels. As previously stated, these can be primary, secondary or tertiary strategies, and may be individual, group or organisationally focused.

Measuring occupational stress and burnout.

Several measures have been designed which examine the role of burnout and occupational stress within the literature. The exact tools used to measure burnout and

occupational stress in the studies examined within this literature review are analysed in this paper's results section under 'Measures'.

Search strategy.

Search terms were developed alongside a specialist librarian and based on a Cochrane review in the area of burnout prevention interventions (Ruotsalainen et al., 2015) (Table 3). Following further meetings and discussions with a specialist librarian, search terms were edited and adapted to produce a final list shown in Table 3. It was decided that the term 'Intervention' and its synonyms would not be used in the systematic search for three reasons:

1. The Cochrane review by Ruotsalainen et al. (2015) on which the search strategy for this systematic review was based, and which established search terms in relation to identifying interventions in reducing burnout in healthcare professionals, did not use the search term 'intervention' or any of its synonyms in its systematic search.
2. The term had specific meanings within the research databases used which were not linked to the type of interventions the systematic search was searching for (See Appendix A).
3. When included in pilot searches supported by specialist librarian before the final search, it reduced search results to 0 (see Appendix B).

Table 3.

Search Terms in relation to PIO.

	Participant search terms (Including setting)	Intervention search terms*	Outcome search terms*
Search Terms	“National Health Service” OR NHS (“health personnel” or “allied health personnel” or “medical personnel” or “Mental health personnel”) or “health service worker*” or "healthcare personnel" or "health care worker*" or "healthcare worker*" or "health worker*" or "health workers" or "health professional*" or "healthcare professional*" or "medical care personnel" or "healthcare staff" or "mental healthcare personnel" or “mental health care worker*” or “mental healthcare worker*” or “mental health worker*” or "mental health professional*" or “mental healthcare professional*" or "mental healthcare staff" "mental health nurse” or "Psychiatric healthcare personnel" or "Psychiatric health care worker*" or “psychiatric healthcare worker*” or “psychiatric health worker*” or “psychiatric health professional*” or “psychiatric healthcare professional*” or “psychiatric staff” or "Psychiatric nurse" or nurs* or physician* or *psychologist* or psychiatrist* or “social worker*” or “occupational therapist*” or counsellor* or Doctor* or *therapist* or pharmacist* or paramedic* or Dentist* or radiographer* or cardiographer* or manager* or management or “medical technician*” or admin*)	(((“Occupational stress”) OR (“Job stress” or “Burnout” or “burn out”) OR ((occupational OR work OR worker* OR working OR workplace OR worksite OR job*) and “stress”)))	(stress OR strain OR anxiety OR depressive OR depression OR burden)) (((“Occupational stress”) OR (“Job stress” or “Burnout” or “burn out”) OR ((occupational OR work OR worker* OR working OR workplace OR worksite OR job*) and “stress”)))

* Several search terms crosses over both ‘Intervention’ and ‘Outcome’ categories but were only used once.

A variety of electronic databases (Medline, PsycINFO, Web of Science and CINAHL) were searched with syntax adjusted as per database requirements (see appendix C, D, E, and F) . Additional parameters were set to remove duplicates. Screening was completed by the lead researcher (DM) with support from other research team member (MJ).

Inclusion and exclusion criteria.

Inclusion criteria:

1. Date: The search strategy examined studies between 1989 and 2019. The year 1989 marked the creation of the internal market and the creation of 'Trusts' by the Margaret Thatcher government as laid out in the Department of Health (1989) white paper. Therefore 1989 was chosen to begin looking at studies published from this time.
2. Exposure of interest: Studies must have participants who have experienced interventions that aimed to impact occupational stress or burnout, with a focus on primary, secondary and tertiary interventions which could involve individual, group or organisational interventions.
3. Location: Studies must have been conducted within the UK.
4. Language: Studies must have been published in English.
5. Participants: Must be NHS staff members.
6. Peer-review: Studies must have been published or cited in a peer-reviewed journal.
7. Reported outcomes: studies must report the outcome of occupational stress or burnout interventions.
8. Study design: Studies can be of any design as long as they fit the inclusion criteria with regards to reported outcomes.
9. Type of publications: Only original studies will be reported.

Exclusion criteria:

1. Date: Older than 1989.
2. Exposure of interest: Experienced either no intervention or an intervention which does not aim to impact burnout or occupational stress.

3. Location: Outside of the UK
4. Language: Non-English studies.
5. Participants: Not conducted on NHS staff.
6. Peer review: not published or cited in a peer reviewed journal meaning the exclusion of grey literature. Although grey literature could have effective interventions, the challenges of finding these papers as well as comparing them to the academic rigours of peer-reviewed studies makes drawing conclusions difficult (Mahood, Van Eerd & Irvin, 2014).
7. Reported outcomes: Do not report the outcomes of an occupational stress or burnout intervention.
8. Type of publications: non-original studies such as review studies, letters and editorial studies will be excluded. However, reference lists will be searched of relevant reviews published in similar topic area for studies which are eligible according to the inclusion and exclusion criteria.

Selection process.

Once the final systematic search had been completed, papers had their titles and abstracts assessed for inclusion based on the chosen eligibility criteria. Full article papers of perceived eligible papers were then accessed for further assessment. The full search process is summarised in the PRISMA diagram in Figure 1.

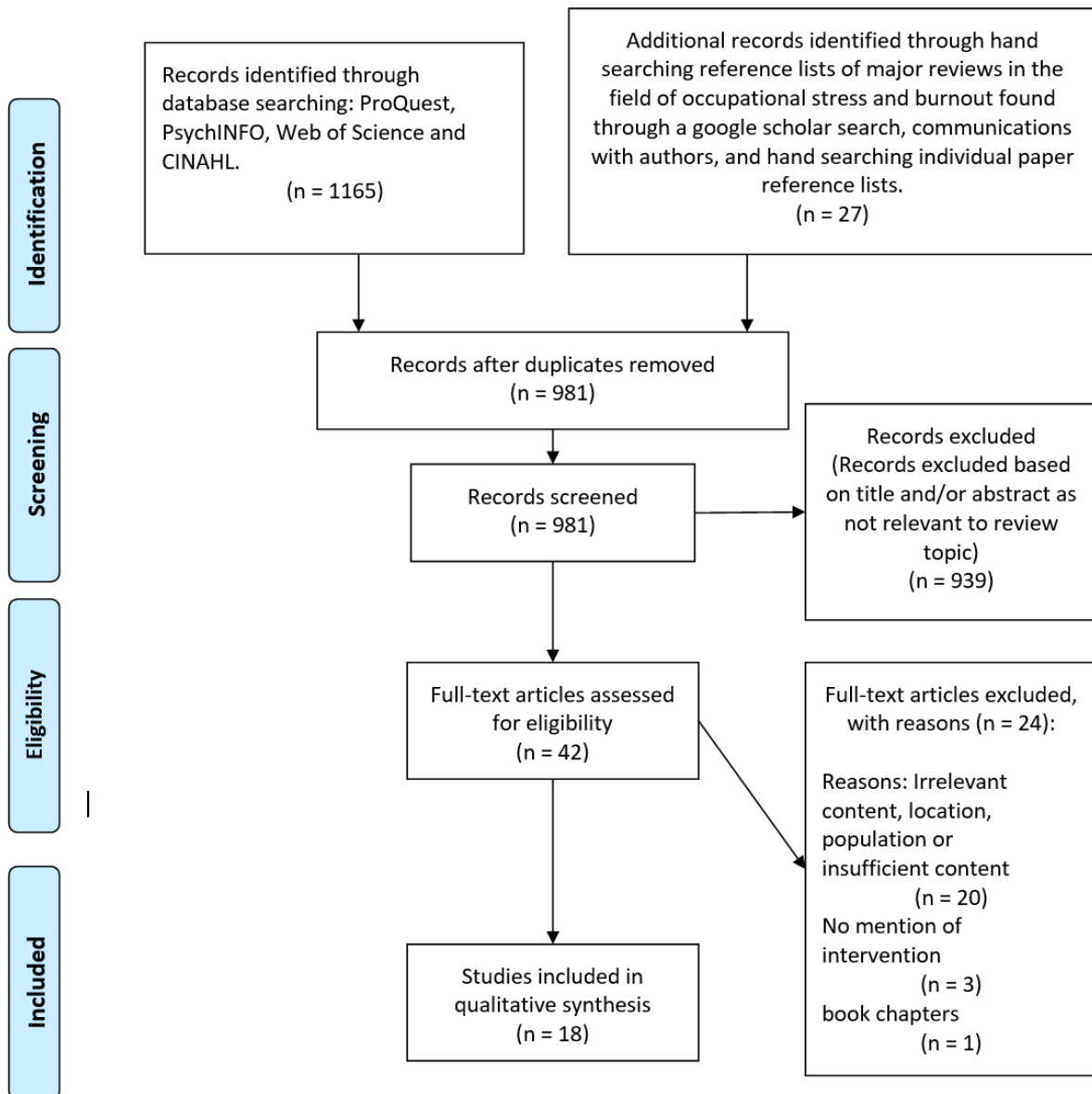


Figure 1. PRISMA diagram

A total of 1165 studies were found via the initial systematic search with an additional 27 being identified through other sources including major reviews found through google scholar search in the field of occupational stress and burnout (Giga et al., 2003; Awa, Plaumann & Walter, 2010; Czabała, Charzyńska & Mroziak, 2011; Ruotsalainen et al., 2015; West et al. 2016; Dreison et al., 2018), communications with authors, and hand searching reference lists. From this, 211 duplicates were removed. A screening on the remaining 981

was conducted with abstracts and titles assessed against the inclusion criteria. Where there was queries as to the relevance of the paper which could not be determined by the abstract, the full paper was sourced and examined. Following this screening process 939 were excluded leaving a total of 42 papers for full paper analysis. Through this process 24 papers were excluded for not being conducted with NHS staff, not examining interventions, and being part of book chapters rather than published studies. This left 18 studies to be reviewed.

Quality assessment.

There are several quality checklist tools that exist for assessing research (Sanderson, Tatt & Higgins, 2007). One of the most established resources for quality appraisal checklists is the Critical Appraisal Skills Programme (CASP) which provides several checklists (CASP, 2019). CASP checklists do not provide a quality appraisal score but show information to aid analysis of quality of study. Therefore ongoing quality assessment was informed by CASP checklists to ensure that the literature quality was reported on.

However, the literature found through the systematic search for this review identified studies which were both RCT and uncontrolled before-and-after-intervention-studies which do not have control or comparison groups. CASP do not provide a quality checklist which assesses both these types of studies in the same tool making quality comparison difficult (CASP, 2019). Therefore, a tool which did assess different types of quantitative studies was selected. The 'Quality Assessment Tool for Quantitative Studies' developed by the Effective Public Health Practice Project (EPHPP) was chosen (EPHPP, 1998). This is a tool developed for use in public health which can be applied to articles of any public health topic area and can be used to assess these studies to help create high quality systematic reviews. It has been shown to be able to provide a high quality, valid and reliable quality appraisal tool in several systematic reviews in the area of interventions including public health nursing (Thomas et al.,

2004) and shows validity in comparison to Cochrane review tools (Armijo-Olivo, 2012). The tool gives an assessment of weak, moderate or strong in eight areas: selection bias, study design, confounders, blinding, data collection methods, withdrawals and dropouts, intervention integrity, and analysis (see Table 4). Studies were classified 'strong' if they had one or less weak ratings and four strong ratings. Studies with two or less weak rating and fewer than four strong ratings were classified as 'moderate'. Lastly, studies with either three or more than three weak ratings were classified as 'weak'.

Table 4.

Quality Assessment Components and Ratings for EPHPP Criteria.

Components	Strong	Moderate	Weak
Selection bias	Very likely to be representative of the target population and greater than 80% participation rate	Somewhat likely to be representative of the target population and 60–79% participation rate	All or other responses or not stated
Study design	Randomized and controlled trials	Cohort analytic, case-control, cohort, or an interrupted time series	All other designs or design not stated
Confounders	Controlled for at least 80% of confounders	Controlled for 60–79% of confounders	Confounders not controlled for, or not stated
Blinding	Blinding of outcome assessor and study participants to intervention status and/or research question	Blinding of either outcome assessor or study participants	Outcome assessor and study participants are aware of intervention status and/or research question
Data collection methods	Tools are valid and reliable	Tools are valid but reliability not described	No evidence of validity or reliability
Withdrawals and dropouts	Follow-up rate of >80% of participants	Follow-up rate of 60–79% of participants	Follow-up rate of <60% of participants or withdrawals and dropouts not described

As shown in Table 5, ten studies were classified as globally ‘weak’, six studies were classified as globally ‘moderate’ and two studies were classified as globally ‘strong’. The main reasons for studies not receiving strong ratings was linked to high drop-out and withdrawal rates, and lack of managing and stating confounders within studies. Understanding the quality of the studies provides an extra overview with which to consider significant results as weaker studies are more prone to bias and validity issues. It is suggested that ‘weak’ studies can be included in systematic reviews, however inclusion should be done with caution and with explicit statement and examination of the flaws within the study (EPHPP, 1998). As such, the quality of studies are commented on throughout this review in relation to the effectiveness of interventions studies utilised with globally weak studies given less weight than those considered globally strong.

Table 5.

'Quality Assessment Tool for Quantitative Studies' Quality Appraisal

Study	Selection bias	Study design	Confounders	Blinding	Data collection method	Withdrawals and dropouts	Global rating
Berry et al. (2012)	Weak	Weak	Weak	Weak	Strong	Weak	Weak
Bunce & West (1996)	Weak	Weak	Weak	Weak	Strong	Weak	Weak
Carson et al. (1999)	Moderate	Strong	Weak	Moderate	Strong	Weak	Moderate
Carson (2005)	Weak	Strong	Weak	Moderate	Strong	Weak	Weak
Cottrell (2001)	Weak	Weak	Weak	Weak	Strong	Weak	Weak
Doyle et al. (2007)	Moderate	Strong	Weak	Moderate	Strong	Weak	Moderate
Ewers et al. (2002)	Strong	Strong	Moderate	Strong	Strong	Weak	Strong
Gardner et al. (2005)	Moderate	Strong	Weak	Moderate	Strong	Weak	Moderate
Grime (2004)	Moderate	Strong	Weak	Moderate	Strong	Weak	Moderate
Hill et al., (2010)	Strong	Weak	Weak	Weak	Strong	Weak	Weak
Kanji et al. (2006)	Strong	Strong	Weak	Moderate	Strong	Weak	Moderate
Meerten et al. (2011)	Strong	Weak	Weak	Weak	Strong	Strong	Weak
Michie (1996)	Weak	Weak	Weak	Weak	Weak	Weak	Weak
Onyett et al. (2009)	Moderate	Weak	Weak	Weak	Strong	Weak	Weak
Redhead et al. (2011)	Strong	Strong	Weak	Moderate	Strong	Weak	Moderate
Reynolds et al. (1993)	Weak	Weak	Weak	Weak	Strong	Weak	Weak
Sharkey & Sharples (2003)	Weak	Weak	Weak	Weak	Strong	Weak	Weak
Stansfeld et al. (2015)	Strong	Strong	Weak	Strong	Strong	Weak	Strong

Data synthesis.

As previously stated, it was deemed that the results of the systematic review be delivered in the form of a narrative synthesis due to the multitude of different designs, methods of measurement and variety in analyses. This covered areas of:

- Understanding the measures used by studies to quantify whether workplace interventions have impacted on occupational stress and burnout for staff working within the NHS.
- Reviewing the range of occupational stress and burnout interventions which have impacted on occupational stress and burnout for staff working within the NHS, and assessing their effectiveness and quality.
- NHS specific issues surrounding both implementation of occupational stress and burnout interventions within an NHS setting and conducting research on occupational stress and burnout interventions within the NHS.

- Potential issues and biases within the literature reviewed, both clinical and theoretical implications, and the implications for future research in this area.

Results

A total of 18 studies were included for review with their characteristics shown in Table 6.

Table 6.

Study Characteristics Table

No.	Author, year and design	Participants characteristics; setting and sample size	Interventions and control conditions (N = number of participants)	Intervention category: individual support/ Training staff in therapy skills / Organisational and team-based interventions	intervention	Outcome for review Additional Measures	Key findings	Limitations	Global rating
1	Berry et al. (2012) Design UC	Sample size/Participants 13 ward staff Participant Characteristics Age: M = 36.31 (SD = 10.33) Gender: 5 males, 8 females Setting: Adult low secure forensic unit	Intervention (N = 13) Content: Teaching staff skills to deal with challenging behaviour Intensity: Attendance at one workshop 3-hour workshop Control (N = 0): No control	TRAINING	combination of organisational primary empowerment scheme interventions, mixed with individual primary psychoeducation interventions	Maslach Burnout Inventory Additional measures Working Alliance Inventory Ward Atmosphere scale Follow up None	No significant difference between pre and post intervention measures.	Small sample size High Attrition rate – 48% No follow up Non-significant increase in emotional exhaustion recorded. Format of the workshop had criticism from participants. A single workshop not enough It was not supported by management	Weak
2	Bunce & West (1996) Design CD	Sample size/Participants 191 Healthcare staff: Midwives, community nurses, health visitors, nurses, physiotherapists, occupational therapists, speech therapists and ward clerics. Participant Characteristics Age: N/A Gender: N/A Setting Hospital and community	Intervention (N = 107 (SMP = 62; IPP = 45)) Content: Stress Management Program (SMP) group – CBT based skills to manage stress, emotions, relationships and problem solving, including relaxation. Innovation Promotion Program (IPP) group – innovative coping discussed by group in response to workplace stressors. Intensity: 1.5 days. Control (N = 84) Staff from comparable professions.	ORGANISATIONAL	Group tertiary therapeutic remedial teamwork.	Job-Induced-Tension (JIT) scale Additional Measures General Health Questionnaire (GHQ)-12 Intrinsic Job Motivation (IJM) scale ; Intrinsic Job Satisfaction (IJS) scale Propensity To Innovate (PTI) scale; Innovation scale Follow up 3 months & 1 year	Significant increase in IJS long term. IPP had significant improvements JIT scores, and significant increases in Innovation.	Not randomised. Staff could not attend training all in one go due to shift patterns Principal researcher delivered training Follow up showed lack of significance High attrition rate	Weak
3	Carson et al. (1999) Design RCT	Sample size/Participants 53 Mental health nurses Participant Characteristics Intervention Age: M = 31.54	Intervention (N = 27) Content: Social support groups Intensity: 2 hours a week for 5 weeks Control (N = 26) Feedback-only	INDIVIDUAL	Combination of group primary team building and individual secondary support mapping	Maslach burnout Inventory GHQ-28 Additional measures DeVilliers Carson Leary (DCL) stress scale Perarlin Mastery Scale Significant Others scale	No significant difference between social support groups and control.	Poor attendance for social support group (only 3/24 attended all sessions) due to staffing issues Intervention was too spread out over 5 weeks Not supported by management Mixed sample from different wards made it hard to engender social support	Moderate

		Gender: 7 male; 20 female Control Age: M = 31.77 Gender: 12 male; 14 female Setting Hospital				Rosenberg Self-Esteem Scale Follow up 6-months	Self-selected volunteers make it better result Small sample		
4	Carson (2005) Design RCT	Sample size/Participants 70 Mental health workers Participant Characteristics Age: M = 41.80 (SD = 9.72) Gender: 7 males, 63 females Setting: NHS trusts	Intervention (N = 38) Content: Self-esteem workshop containing 10 modules. Intensity: Attendance at one workshop Control (N = 32): Wait list	INDIVIDUAL	individual tertiary psychotherapy intervention	Maslach burnout Inventory GHQ-12 Additional measures Perceived Stress Scale Rosenberg Self-Esteem Scale Heatherton Self-Esteem Scale Self-Esteem Visual Analogue Follow up None	No significant difference between self-esteem workshop attendees and waitlist in terms of burnout.	Study did not assess potential moderators of stress apart from self-esteem Study did not address how different groups respond to self-esteem enhancement.	Weak
5	Cottrell (2001) Design: UC	Sample size/Participants 31 Mental health nurses Participant Characteristics Intervention: Age: M = 42 years Control: None Setting Mixed	Intervention (N = 31): Content Greater managerial support and contractual peer supervision Intensity: Inconclusive Control (N = 0): No control	INDIVIDUAL	combined individual secondary supervision support intervention with an organisation secondary workload management intervention	Pressure Management Indicator Follow up None	Presents no data on the nature or effectiveness of the intervention.	Small sample size Not all staff experience the same level of distress Only 53% response rate Lack of longitudinal data on stress Lack of information in relation to organisational issues collected by the PMI measure Anonymity inhibits specific follow up Collected data on stress but doesn't analyse the interventions. No information on intensity of suggested intervention to be followed up.	Weak
6	Doyle et al. (2007) Design RCT	Sample size/Participants 26 Qualified staff including: nursing and non-nursing staff Participant Characteristics Intervention Age: M = 37.79 Gender: 5 male; 9 female Profession: Nursing: 9; Non-nursing: 5 Control Age: M = 38.92 Gender: 2 male; 10 female Profession: Nursing: 7; Non-nursing: 5 Setting:	Intervention (N = 14): Content: Psychosocial intervention (PSI) training to provide staff with the skills and knowledge to implement PSI into their clinical practice. Intensity: 16 weekly three-hour sessions. 48 hours total Control (N = 12): Wait-list	TRAINING	combination of organisational primary empowerment scheme interventions, mixed with individual primary psychoeducation interventions	Maslach burnout Inventory Additional Measures 20-item knowledge of schizophrenia Nursing Care Plan Psychosocial Skills Checklist Follow up None	No significant differences between psychosocial intervention training group and control group in terms of burnout.	Small sample Did not replicate results of previous study (Ewers et al., 2002) Organisational changes such as agenda for change Shorter course No improvement in other areas of MBI – exhaustion and depersonalisation	Moderate

7	Ewers et al. (2002) Design: RCT	Adult forensic medium secure unit Sample size/Participants 20 Qualified forensic mental health nurses Participant Characteristics Age: M = 42.55 years Gender: 14 male; 6 female Years of experience: M = 11.85 (SD = 6.24) Setting Forensic-Regional secure unit	Intervention (N = 10) Content: Psychosocial intervention (PSI) training which aimed to provide training for staff working with schizophrenia with the skills for reducing stress and improving functioning. Intensity: 20 days training Control (N = 10) Wait-list	TRAINING	combination of organisational primary empowerment scheme interventions, mixed with individual primary psychoeducation interventions	Maslach burnout Inventory Additional Measures 30-item Multiple Choice Questionnaire to measure knowledge of schizophrenia and psychological approaches Purpose-made attitudes Measure Follow up None	Psychosocial intervention training group had significantly lower scores in terms of EE and DP and higher scores on PA compared to the wait-list control.	Specialised nature of sample makes it hard to apply to others Self-selected volunteers make it better result Principal researcher worked in a secure unit where the research took place, also collected the data and ran the training No follow up Small sample	Strong
8	Gardner et al. (2005) Design: RCT	Sample size/Participants 138 clinical staff Participant Characteristics Age: M = 37 years Gender: 25 male, 113 female. Profession: clinical staff*/nurses (30%), care assistants (37%), psychologists, speech therapists, physiotherapists and social workers (20%), doctors (3%); administrative staff (10%). Setting Mixed	Intervention (N = 57 cognitive intervention and 44 for behavioural coping): Content 1 - Cognitively based stress management training to modify cognitive appraisals 2 - Stress management training behavioural coping skills Intensity: :3 half day (3.5 hour) workshops over 3 weeks. Control (N = 37): Waiting list control group.	INDIVIDUAL	individual primary cognitive group training intervention	General Health Questionnaire – 12 Mental Health Professionals Stress Scale Eysenck Personality Questionnaire / Revised. Short Scale Ways of Coping Questionnaire Follow up 3-month	Reduction in symptom ratings in those who had clinically significant GHQ scores (in behavioural and cognitive groups)	No significant changes in measures of primary and secondary care. Small sample size Author delivered interventions Lack of pure randomisation as those willing to wait were placed on waiting list control High attrition rate = 25% Cross contamination of interventions with all groups reporting an improvement in mood even the control after 3 weeks No information about differences between demographics of intervention and control groups	Moderate
9	Grime (2004) Design: RCT	Sample size/Participants 48 Public sector employees Participant Characteristics Intervention: Age: M = 41 years Gender: 13 male; 11 female Local authority workers – 13 NHS workers - 11 Control: Age: M = 37 years	Intervention (N = 24): Content Interactive, computerized CBT program (plus conventional care) Intensity: : 8 weekly sessions. Control (N = 24): Conventional care (treatment as usual)	INDIVIDUAL	individual tertiary psychotherapy intervention	Hospital Anxiety and Depression Scale Attributional Style Questionnaire Follow up 3 month & 6 month	Lower depression and negative attributional style scores at post-test, Lower depression, anxiety and attributional style scores significant at 1 month Not significant. at 3 months	Small sample size due to poor recruitment Some individuals were receiving dual treatment such as also having face to face counselling 2/3 of individuals in intervention group completed full 8 sessions Some individuals completed follow up data though didn't finish the programme due to 'intention to treat' The differences were not statistically significant at 3- and 6-months post-treatment. Non-participation was common and related to access problems, preference for other treatments, time commitment, scepticism about the intervention and the employer connection.	Moderate

		Gender: 7 male; 17 female Local authority workers – 12 NHS workers - 12 Setting Mixed					Attrition rate at follow up 32%.		
10	Hill et al., (2010) Design UC	Sample size/Participants 19 Qualified and non-qualified nurses Participant Characteristics Intervention: Age: M = 36 years Gender: 5 male; 14 female Control: No control Setting addiction care inpatient	Intervention (N = 19) Content: Whole team <i>OSCAR</i> training incorporating organisational and individual issues. Intensity: 2 full day training separated 2 weeks apart. Control (N = 0) No control	ORGANISATIONAL	combined organisational primary empowerment scheme intervention with an individual primary psychoeducation intervention	Demographics Questionnaire Maslach Burnout Inventory Follow up 1 month	Non-significant improvement in areas of the MBI in emotional exhaustion, depersonalisation. Significant improvement recorded in the rating of personal accomplishment on the MBI.	Simple design - No control group Follow up only 1 month after training Staff work multiple unpaid overtime hours on a weekly basis potentially affecting recruitment	Weak
11	Kanji et al. (2006) Design RCT	Sample size/Participants 93 Nursing students Participant Characteristics Intervention - AT: Age: M = 25.3 years Gender: 4 male; 28 female Intervention – AC: Age: M = 28.6 years Gender: 2 male; 28 female Control: Age: M = 26.9 years Gender: 2 male; 29 female Setting Nursing school	Intervention (N = Autogenic – 32, Attention control 30): Content 1 - Autogenic training 2 - Laughter therapy Intensity: : 8 hour long weekly sessions with 20 minutes practice. Control (N = 31): Waiting list	INDIVIDUAL	individual primary psychoeducation intervention	Maslach Burnout Inventory Follow up 8 month & 11 month	No effect on burnout outcomes in either the autogenic training or the laughter therapy groups in comparison to control waiting list.	High dropout at all stages - difficulty of additional intervention on top of clinical and academic workload Further follow up required due to unusual increase in use between 8 months and 11 months	Moderate
12	Meerten et al. (2011) Design: UC	Sample size/Participants 121 doctors Participant Characteristics Intervention: Not reported Control: None Setting Mixed	Intervention (N = 114 (engaged in intervention)): Content Extended consultation with a psychiatrist also delivering psychodynamic therapy Intensity: : Average 6 weekly sessions. Control (N = 0): No control	INDIVIDUAL	individual tertiary psychotherapy intervention	Clinical Outcomes in Routine Evaluation-Outcome Measure. Brief Symptom Inventory-9 Maslach Burnout Inventory 20-item bespoke service users views questionnaire Follow up None	A statistically significant improvement in scores on all three questionnaires was found after intervention; however, scores on one subscale, the risk domain of the Clinical Outcomes in Routine Evaluation - Outcome Measure, did not change significantly.	No control group in terms of the approach used and service provided at MedNet; response bias; and that data were based on self-report measures only Some individuals had 6 sessions while others had 20. No long term follow up. Attrition rate of 29%	Weak

13	Michie (1996) Design UC	Sample size/Participants 92 Hospital staff Participant Characteristics Age: M = N/A Gender: N/A Setting Hospital	Intervention (N = 92) Content: Individual counselling sessions Intensity: 2 or more sessions	INDIVIDUAL	individual tertiary psychotherapy intervention	Self-developed mood questionnaire Absence levels Follow up 6-month	Significant improvement in EE on the MBI. Highly significant reductions in anxiety and depression and highly significant improvements in satisfaction with self, life outside work, functioning at work and outside work.	No control group High dropout rate (66%) by 6 month follow up Non-validated measure Lack of demographic information Lack of information about intervention Varied number of days amongst participants Self-selected volunteers make it better result	Weak
14	Onyett et al. (2009) Design UC	Sample size/Participants 327 Professional and paraprofessional direct care and support staff Participant Characteristics Intervention: N/A Control: No control Setting Mixed	Intervention (N = 14 teams – 230 participants): Content Organization directed/whole team communication training Intensity: 7 days (2 initial days then following days spread out at 1 day every 3 weeks) . Control (N = 0): No control group.	ORGANISATIONAL	group primary team building intervention	Team member Questionnaire Follow up None	Improvements on team working significant across the sample No significant result on other outcome measures though scores suggested positive result of intervention.	Organisational turbulence during implementation of programme No follow up measures Lack of significant results Not signing up all intermediate managers to ensure programme was completed Attrition rate of 31%	Weak
15	Redhead et al. (2011) Design RCT	Sample size/Participants: 21 Qualified and non-qualified nurses Participant Characteristics Intervention: Age: M = 39.4 years Gender: 2 male; 10 female Control: Age: M = 42.6 years Gender: 2 male; 7 female Setting Low secure units	Intervention (N=12) Content: Psychosocial intervention training (PSI) covering a broad range of PSI including cognitive behavioural approaches for managing symptoms. Intensity: 16 half-day sessions delivered over 8 months. Teaching sessions supplemented by small group supervision, Control (N= 9) Work as usual	TRAINING	combination of organisational primary empowerment scheme interventions, mixed with individual primary psychoeducation interventions	Maslach burnout Inventory. Additional Measures 20-item Multiple Choice Questionnaire to assess knowledge of schizophrenia and psychological approaches Attitudes to PSI scale Audit of care plans using Psychosocial Intervention Skills List Follow up None	No significant difference between psychosocial intervention training group and control in terms of EE and PA sub-scales. The intervention group had significantly lower scores than the control group in terms of the DP sub-scale.	Convenience sample who volunteered Small sample size No comparison data from those who didn't take part Only MBI had been systematically evaluated with the rest previously been used in studies. Potential for type one errors due to not formally correcting for multiple tests Groups worked together so skills may have been passed from intervention group to control group and impacted on practice and results	Moderate
16	Reynolds et al. (1993) Design UC	Sample size/Participants 62 Health service workers Participant Characteristics Age: M = 39.7 years Gender: 62 female Setting Hospital and community	Intervention Content: Stress management training Intensity: 6 weekly 2-hour sessions	INDIVIDUAL	Combination of individual psychoeducation and individual relaxation intervention.	GHQ-12 Additional Measures Job and non-job satisfaction Session impact Scale Session Evaluation Questionnaire Follow up 1-month, 3-month	Significant reductions in psychological distress. Session impact significantly related to life satisfaction, suggesting techniques taught on program are	No control group Self-selected volunteers could make it better result as scores were self-report Short follow up Small sample	Weak

17	Sharkey & Sharples (2003) Design: UC	Sample size/Participants 41 Mixed mental health professionals Participant Characteristics Intervention: Age and gender not reported Control: No control Setting Mental health teams	Intervention (N = 41) Content Risk management in mental health Intensity: Six monthly three and a half hour workshops Control (N = 0): No control	ORGANISATIONAL	individual primary team communication skills intervention	Occupational stress indicator (OSI) Healthcare-related work pressure scale (adapted from the nurse stress index, NSI) Follow up None	transferable to work settings. Of 28 OSI subscales, there were significant improvements only on two on the sources of stress subscale. Of the 17 NSI items, there were significant improvements on 5 items, for instance there was less stress from dealing with relative's post intervention.	Small non-controlled study No long term follow up to check whether there was sustained change Lack of availability of participants hindered data collection of both pre and post measures. Unforeseen difficulties arose in the personal lives of participants potentially affecting the results Attrition rate of 35%	Weak
18	Stansfeld et al. (2015) Design: RCT-cluster	Sample size/Participants: 4 clusters involving 350 employees (including Mental Health Trust Managers (N = 21)) Participant Characteristics Intervention total (N = 3 cluster / 283): Age: 46.9 Gender: 74 male, 209 female Control total (N = 1 cluster / 67): Age: 45.6 Gender: 10 male, 57 female Setting Mental Health Trusts	Intervention (N = 3 clusters/231 employees) Content: E-learning package for Mental Health Trust Managers with face-face sessions alongside telephone and email support. Intensity: Delivered in weekly or two weekly modules over a 3-month period. Control (N = 1 cluster/67 employees) No intervention	ORGANISATIONAL	organisational secondary risk analysis and management intervention	Job strain as measured by the Karasek's Job Content Questionnaire Additional Measures Warwick Edinburgh Mental Wellbeing Scale Sickness absence GHQ-12 Qualitative interviews Follow up None	A very small effect on improving employee wellbeing with WEMWBS scores falling in the intervention group in comparison to control – unknown whether it was significant or not. No other significant effects found. Qualitative themes were sources of stress were organisational change, job insecurity, insufficient resources and family life. Also the intervention was deemed easy to sue, relevant to the role, with the support deemed positive, however lack of senior management support was an issue.	Low adherence amongst managers The interval between intervention and follow up was short Organisational change made it a problematic time to introduce an intervention to reduce stress in employees Attrition rate of 33% Significance not reported.	Strong

UC=Uncontrolled Design; RCT=Randomised Control Design; CD=Control design

Descriptions of studies.

All 18 studies took place in the UK and were published between 1989 and 2019. All 18 studies had quantitative elements with only one study utilising a mixed methods approach including qualitative data (Stansfeld et al., 2015). Nine of the studies were RCT's (Carson et al. 1999; Carson, 2005; Doyle et al., 2007; Ewers et al., 2002; Gardner et al, 2005; Grime, 2004; Kanji et al., 2006; Redhead et al., 2011; Stansfeld et al., 2015). Of these studies they compared an intervention group to a treatment as usual group (Grime, 2004; Redhead et al., 2011), to waiting list group (Carson, 2005; Doyle et al., 2007; Ewers et al., 2002; Gardner et al, 2005; Kanji et al., 2006) and to a feedback-only group (Carson et al., 1999). The other eight were uncontrolled design (Bunce & West, 1996; Berry et al., 2012, Cottrell, 2001; Hill et al., 2010; Meerten et al., 2011; Michie, 1996; Onyett et al., 2009; Sharkey & Sharples, 2003). All studies took place on NHS sites with four studies in a forensic secure unit (Berry et al., 2012, Doyle et al., 2007; Ewers et al., 2002; Redhead et al., 2011), two within a hospital (Carson et al., 1999; Michie, 1996) one within an addiction's unit (Hill et al., 2010), one in a nursing school (Kanji et al., 2006), nine containing a mix of teams and sites (Bunce & West, 1999; Carson, 2005; Cottrell, 2001; Gardner et al, 2005; Grime, 2004; Meerten et al., 2011; Onyett et al., 2009; Sharkey & Sharples, 2003; Stansfeld et al., 2015).

Sample characteristics.

All studies included both male and female participants over the age of 18 with the total number of participants combined across 18 studies being 1495 . All studies took place in the UK with participants who worked for the NHS. The staff mix of the studies included nurses, trainee nurses, care assistants, psychologists, speech therapists, occupational therapists, physiotherapists, social workers, doctors and administrative staff. Nurses were the main participants across studies. None of the studies reported the race and ethnicity or the

religion of the participants. All studies reported either ages or means with the mean age of participants ranging from 26.9 to 46.9. Marital status and educational level was not reported, however professional status alluded to the level of educational attainment by some participants.

Measures used.

Stress and burnout measures.

Nine studies (Berry et al., 2012; Carson et al., 1999; Carson, 2005; Doyle et al., 2007; Ewers et al., 2002; Hill et al., 2010; Kanji et al., 2006; Meerten et al., 2011; Redhead et al., 2011) utilised the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1986) which has shown consistent reliability and validity with Cronbach's alpha 0.90 for emotional exhaustion, 0.79 for depersonalization, and 0.71 for personal accomplishment. The MBI is a 22-item (7-point Likert-scale) measure designed to assess three elements of burnout: emotional exhaustion (nine items), depersonalization (five items) and personal accomplishment (eight items).

Cottrell (2001) opted for the Pressure Management Indicator (PMI) (Williams & Cooper, 1998) which is a 120-item self-report measure which examines stress in several areas. The PMI has the benefit of a very large database ($n > 20000$) from which the normative scores are derived suggesting high validity and reliability. However the measure itself was only used to identify current levels, and not as a measure of the intervention used in Cottrell's (2001) study.

Sharkey and Sharpie (2003) utilised the Occupational Stress Indicator (OSI) (Cooper et al., 1988) to assess stress levels. The indicator comprises a biographical questionnaire and six subscales, each using a six-point Likert scale. The OSI has been used widely in health settings to analyse occupational stress levels and is a reliable and validated scale (Robertson et al., 1990; Kirkcaldy & Martin 2000). Sharkey and Sharpie (2003) also used an adapted

version of the 'managing the workload' and 'dealing with patients and relatives' subscales from the 30-item (six subscales using a five-point Likert-type rating scale) self-report Nurse Stress Index (NSI) (Harris 1989). The NSI was found to be reliable and have reasonable construct-validity in a study of 117 front-line nurses (Cooper & Mitchell 1990).

Stansfeld et al. (2015) utilised the job strain sub-scale of Karasek's Job Content Questionnaire (Karasek et al., 1979). This was 15-item (4-point Likert scale) questionnaire assessing job strain in several areas. Karasek et al. (1979) suggested high reliability and validity of the measure and has been used in NHS research (Williams, & Smith, 2013).

Carson (2005) used the Perceived Stress Scale (PSS) (Cohen et al., 1983). This was a 10-item scale (rated on a five-point Likert scale) which examined how much stress an individual had experienced over the past month. The PSS has adequate internal and test-retest reliability (Cohen et al, 1983 ; Cohen and Williamson, 1988).

Bunce and West (1996) used the Intrinsic Job Motivation (IJM) scale and Intrinsic Job Satisfaction (IJS) scale (Warr, Cook & Wall, 1979). These were 6-item (IJM) and 7-item (IJS) scale rated on a seven-point Likert scale. The scales were suggested to have good internal reliability (Warr et al., 1979).

Carson et al. (1999) used the Devilliers Carson Leary Stress Scale (DCL scale) (Carson et al., 1997) to measure specific ward based occupational stressors. It covers five areas across 30 items. The measures was suggested to have good validity and reliability (Carson et al., 1997).

Onyett et al. (2009) elected to use a self-developed measure called the Team Member Questionnaire (TMQ) which was based on several pre-existing valid measures, however no evidence of validity of the TMQ was reported.

Mental and General Health Measures.

Several valid and reliable mental and general health measures were also used to understand the impact of burnout interventions. Stansfeld et al. (2015) utilised the Warwick Edinburgh Mental Wellbeing Scale (WEMWS) (Tennant et al., 2007) to assess levels of positive mental health. Grime (2004) opted to use the Hospital Anxiety and Depression Scale (HADS) (Snaith & Zigmond, 1994) to assess for anxiety disorders and depression. The General Health Questionnaire (GHQ-12; GHQ-28) (Goldberg, 1978; Goldberg, 1988) was used in a number of studies in this review (Bunce & West, 1996; Carson et al., 1999; Carson, 2005; Gardener et al, 2005; Reynolds et al., 1993; Stansfeld et al., 2015) to measure general levels of distress. Meerten et al. (2011) used both the Clinical Outcomes in Routine Evaluation- Outcome Measure 13 (CORE-OM 13) (Evans et al., 2000) and the Brief Symptom Inventory-9 (BSI-9) (Derogatis 1993) to gain an understanding of general mental health in participants. Carson et al. (1999) and Carson (2005) assessed changes in self-esteem with the Rosenberg Self-Esteem Scale (Wycherley, 1987; Rosenberg, 1965), and the Heatherton Self-Esteem Scale (Heatherton & Polivy, 1991).

Other measures.

Several measures were used which had no validity or reliability reported due to either being self-developed or quite general in their approach. Some studies used self-developed bespoke questionnaires to assess individuals' experiences of the intervention (Meerten et al., 2011), or their understanding of schizophrenia, psychoses and psychological approaches (Ewers et al., 2002; Doyle et al., 2007; Redhead et al., 2011). Others used self-developed attitude measures to identify whether subjects had positive attitudes towards their patients' care (Ewers et al., 2002), and to assesses staff's attitude PSI (Redhead et al., 2011). Additional measures included self-developed mood measures (Michie, 1996), auditing care plans to see use of interventions (Redhead et al., 2011, Doyle et al., 2007), checking sickness absences before and after intervention (Michie, 1996), and auditing NHS databases for

sickness absences (Stansfeld et al., 2015) to aid understanding of the impact of burnout. Carson et al. (1999) and Carson (2005) also used a self-developed Self-Esteem Visual Analogue to assess change in self-esteem. Bunce and West (1996) uses two innovation measures ('Propensity to Innovate' scale (Burningham & West, 1995) and 'innovation' scale (Bunce & West, 1995)). Reynolds et al. (1993) utilised a job satisfaction and non-job satisfaction rating.

Interventions.

Interventions utilised by reviewed studies.

The interventions used across studies were highly variable in both size and method of intervention. After reviewing the specific interventions in the studies in this literature review, and for the purposes of reporting the results, these were categorised into three further overarching themes above and beyond those suggested by Günthner and Batra (2012) and listed in Table 1. These themes include: *Individual support* – Therapeutic interventions for staff to help them manage the effects of occupational stress/burnout, *Training staff in therapy skills* - Therapeutic skills training to increase the number of successful outcomes with clients to improve staff sense of accomplishment and reduce feelings of occupational stress/burnout, and *Organisational and team-based interventions* – To improve organisation/team-based working and empower staff to feel supported in their work, thus reducing occupational stress/burnout. The nature of the intervention is also noted (as per Table 1) including information pertaining to whether the intervention was classified as individual, group or organisational, and whether it was primary, secondary or tertiary. Following this breakdown, a summary of studies from across the three categories with interventions which showed a significant effect is included for an understanding of effectiveness.

Individual support. Nine studies (Carson et al., 1999; Carson, 2005; Cottrell, 2001; Gardner et al., 2005; Grime, 2004; Kanji et al., 2006; Meerten et al., 2011; Michie, 1999;

Reynolds et al., 1993) fell under the theme of utilising forms of individual support as an intervention. With regard to quality assessment of these studies, none were considered globally strong, four were considered globally moderate (Carson et al., 1999; Gardner et al., 2005; Grime, 2004; Kanji et al., 2006), and five were considered globally weak (Carson, 2005; Cottrell, 2001; Meerten et al., 2011; Michie, 1999; Reynolds et al., 1993).

Gardner et al. (2005) used an individual primary intervention in the form of cognitive stress-based management group training 57 staff to cognitively appraise situations to reduce stress, and a behavioural coping skills group training 44 staff to be more assertive and manage their time to reduce stress, both of which were versus a control waiting list group of 37 staff. The results showed there was a reduction in scores on the GHQ-12 for both the cognitive and behavioural groups versus the waiting control at three-month follow up. However, in contrast to the significant results shown by Gardner et al. (2005), Kanji et al. (2006) who also used an individual primary intervention of psychoeducation did not find any difference between the intervention groups and 31 staff control group. Kanji et al. (2006) utilised an 8-week hour-long autogenic training (Kanji, 1997) which focused on training 32 individuals to use muscle relaxation, slowing of the heart rate and biofeedback in the body to reduce stress. The second intervention group of 32 staff were trained to use laughter therapy. Though both Gardner et al. (2005) and Kanji et al. (2006) used primary interventions, Gardner et al. (2005) study utilised more evidence-based intervention (Cognitive Behavioural Therapy) (Varvogli & Darviri, 2011), while Kanji et al. (2006) also struggled with high dropout rates.

Cottrell (2001) utilised a mix of methods in attempting to reduce occupational stress and burnout in individuals which involved a secondary individual intervention approach using supervision support, combined with an organisation secondary intervention in the form of workload management. Though Cottrell (2001) described the intervention delivered to 31

staff thoroughly, no outcome data was collected on whether the intervention reduced burnout or occupational stress for staff, neither was there a report on the intensity of the intervention.

Carson et al. (1999) utilised a mixed group primary team building and individual secondary support mapping intervention to examine whether social support groups could help reduce occupational stress in nurses. Carson et al. (1999) delivered a weekly two-hour social support group across five weeks to 53 nurses to see the effect on burnout versus a feedback-only control group. The results found no significant differences between those who attended the workshop and those who were in the control group.

Four studies (Carson, 2005; Grime, 2004; Meerten et al., 2011; Michie, 1999) elected to research whether an individual tertiary psychotherapy intervention reduced occupational stress or burnout in staff. Carson (2005) delivered a single self-esteem workshop to 32 NHS staff and assessed whether it reduced burnout and improved self-esteem versus a waiting list control group of 32. The results found no significant differences between those who attended the workshop and those who were in the control group. Grime (2004) assessed an 8-week computerised Cognitive Behavioural Therapy (cCBT) intervention for 24 staff versus a control group of 24. Grime (2004) found significantly lower mean depression scores and attributional style scores at post-test and at one month follow up, with significantly lower mean anxiety scores at one month follow up, however there was no significant difference between intervention groups and control at three-month or six-month follow up. Grime (2004) had difficulty getting all staff to complete the eight sessions of the intervention with around 66% completing, with some individuals being dual treated with counselling as well as the intervention, which may have impacted on outcomes. Meerten et al. (2011) utilised an uncontrolled study to examine the impact of 6-weeks of weekly extended consultations including elements of psychodynamic therapy sessions on a sample of 114 doctors. The results showed a significant improvement across all aspects of measures apart from the risk

domain of the CORE-OM, the depersonalisation of the MBI and personal accomplishments aspect of the MBI. Meerten et al. (2010) had some individuals having up to 20 sessions of intervention, with the paper not stating the exact ratio of psychodynamic therapy to consultation time making it difficult to understand the true format of the intervention. Michie (1999) utilised an uncontrolled study to examine the impact of occupational health support sessions with the study using sample of 92 individuals who had used the service. The results suggested significant improvement in mood both after the sessions and 6-months later, but the measures used were self-developed and were not validated. Absences decreased for clients six months after the intervention also but were not quantitatively analysed. The number of sessions were not stated for each participant and dropout rates were high.

Reynolds et al. (1993) utilised an uncontrolled design study to assess the combination of individual psychoeducation intervention and individual relaxation intervention delivered in a group format. The study examined a sample of 62 healthcare staff who were delivered weekly 2-hour sessions over six weeks of Stress Management Training (SMT). The results suggested significant improvement in GHQ-12 scores after intervention. The number of sessions attended by all individuals was not stated, and a control group was not utilised.

In summary, there were five individual support themed interventions which showed a significant level of effectiveness. These were Gardner et al. (2005) which utilised an individual primary cognitive stress-based management group training intervention, with Reynolds et al. (1993) using a combination of individual psychoeducation intervention and individual relaxation intervention, with Grime (2004), Meerten et al. (2011) and Michie (1999) utilising an individual tertiary psychotherapy intervention. All five significantly improved mood across various measures, however only Meerten et al. (2011) improved scores on part of a burnout measures (Emotional exhaustion on the MBI). The only interventions to show significant result at follow up was Grime (2004), Michie (1999) and

Reynolds et al. (1993). Grime (2004) had significant improvement at the 1-month mark, but no further improvements were recorded at later time points, Reynolds et al. (1993) showed improvement at 3-month follow up but only on health measures, Michie (1999) showed improvement in mood measures and absence rates 6-months later but did not use validated measures.

Training staff in therapy skills. Four studies (Berry et al., 2012; Doyle et al., 2007; Ewers et al., 2002; Redhead et al., 2011) fell under the theme of utilising training staff in therapy skills interventions. All four used a combination of organisational primary empowerment scheme interventions, and individual primary psychoeducation interventions. For all studies, the organisational section of the intervention aimed to empower staff teams to work together using similar interventions, while the individual psychoeducation intervention was to enable staff to get positive outcomes from their work with clients thus improving their sense of personal achievement. With regard to quality assessment of these studies, one study was considered globally strong (Ewers et al., 2002), two were considered globally moderate (Doyle et al., 2007; Redhead et al., 2011), and one was considered globally weak (Berry et al., 2012).

The earliest of the studies utilising this form of intervention was Ewers et al. (2002) who examined the effect of 20 days of Psychosocial Intervention (PSI) training on burnout and occupational stress over six months for 10 forensic mental health nurses versus a control waiting list of 10 forensic mental health nurses. The PSI training intervention focused on schizophrenia and consisted of developing engagement skills, knowledge of Cognitive Behavioural Therapy (CBT) interventions, family interventions, psychoeducation, and coping strategies (Ewers et al. 2002). The results found, in contrast to Doyle et al. (2007), the PSI group had significantly lower scores in the emotional exhaustion and depersonalization, and

higher scores in the area of personal accomplishment, on the MBI in comparison to the control group. The PSI group also significantly improved their knowledge about schizophrenia and attitudes towards schizophrenia scores. Of all the interventions within this category, this had the longest training period for staff of 20 days in comparison to 16 half-day sessions for the other studies (Doyle et al., 2007; Redhead et al., 2011).

Doyle et al. (2007) similarly to Ewers et al. (2002), assessed the effect of a 16-week 3-hourly PSI for 14 nursing and non-nursing staff versus a 12 staff waiting list control group. The results found a significant increase in knowledge scores for PSI group in comparison to the control group at post-assessment. Though the PSI group significantly improved their attitude scores pre-intervention to post-intervention, it was not significantly different to the control group. There was no significant differences between the PSI group pre and post intervention, or between the PSI group and the control group. Doyle et al. (2007) reported experiencing difficulty controlling for external variables such as major organisational change in the form of Agenda for Change (Buchan & Evans, 2007) during the study, and the control group staff having a higher 'positive attitudes to schizophrenia' score than the intervention group at baseline, thus potentially skewing the comparison analysis.

Redhead et al. (2011) aimed to emulate the study by Doyle et al. (2007) by assessing the effect of a 16-week 3-hourly PSI for twelve nursing and non-nursing staff versus nine staff working as usual. The results found a significant increase in knowledge and attitudes scores for both qualified and unqualified staff in the PSI group in comparison to the control group at post-assessment. The only result that showed significant improvement within the PSI group (qualified staff) was a significant increase in personal achievement scores on the MBI while there was no significant results with regards to burnout within the PSI group for unqualified staff. Redhead et al. (2011) suggested that results could have been skewed due to

lack of separation between control group and intervention group, with the control group learning the skills from the intervention group over the course of the study.

Berry et al. (2012) assessed the effect of a single 3-hour workshop for 13 ward staff training them to work with challenging behaviours. The study reported no significant results between pre and post intervention. Berry et al. (2012) suggested the small sample size limited the power of analysis, with results even showing a non-significant increase in emotional exhaustion on the MBI over the course of the intervention rather than any improvements.

In summary, the training staff in therapy skills themed interventions which showed a significant level of effectiveness were Ewers et al. (2002) and Redhead et al. (2011). Both used a combination of organisational primary empowerment scheme interventions to get staff teams to work together, and individual primary psychoeducation interventions to improve staff's clinical outcomes with clients. Both significantly improved scores on the MBI, with Ewers et al. (2002) improving scores across all areas of the MBI, and Redhead et al. (2011) improving scores on the depersonalisation part of the MBI. However, neither reported follow-up scores at later time points.

Organisational and team-based interventions. Five studies fell under the theme of utilising forms of organisational and team-based interventions. Of the five studies, only Stansfeld et al. (2015) was an RCT, Bunce and West (1996) was a non-randomised Controlled Design, while the other three studies all had no control group (Onyett et al., 2009; Hill et al., 2010; Sharkey & Sharples, 2003). All four used different variations of interventions. With regard to quality assessment of these studies, one study was considered globally strong (Stansfeld et al., 2015), with the other four considered globally weak (Bunce & West, 1996; Onyett et al., 2009; Hill et al., 2010; Sharkey & Sharples, 2003).

Bunce and West (1996) used a group tertiary intervention in the form of therapeutic remedial teamwork. This was done via delivering a Stress Management Program (SMP) and Innovation Promotion Program (IPP) to 118 staff (SMP= 66; IPP = 52). The SMP were taught CBT and relaxation skills, while the IPP were taught innovative coping. This was delivered across 1.5 days for both groups. The results found the SMP significantly improved job satisfaction results at the 1-year follow up in comparison to control group. The IPP group had significant improvements in JIT scores, and significant increases on Innovation measures in comparison to control group. Bunce and West (1996) reported limitations in that some participants were encouraged to take part by their line manager, while others volunteered, with self-selection bias potentially affecting the scores. Also, staff being unable to attend training all in one go due to shift patterns made participation difficult.

Sharkey and Sharples (2003) used an individual primary intervention in the form of developing team's communication skills by training 41 staff in risk management in mental health to reduce stress. The intervention aimed to enable participants to discuss and make decisions within mental health risk management with their teams through a combination of group discussions, presentations, activities and reading between workshops with facilitators providing support clinically over the course of the six monthly three and a half hour workshops (Sharkey & Sharples, 2001). The results found there were significant medium effect on changes to only two of the 'sources of stress' subscale of the OSI; 'factors intrinsic to the job' and 'the managerial role' across time. Of the 17 NSI items, there were significant medium to large effect in changes on five items; 'fluctuations in workload', 'dealing with relatives', 'difficulty dealing with aggressive people', 'difficult patients' and 'involvement in life and death situations'. Sharkey and Sharples (2003) found there was external variables they could not control for which impacted on the study's results, such as personal crisis's and lack of availability of participants.

Onyett et al. (2009) utilised a group primary intervention in the form of team building. The self-developed intervention by Onyett et al. (2009) assessed whether leadership training delivered to 14 teams involving 230 participants for 7-days across a 3-week period had an impact on burnout and stress. The results found a significantly small effect on improvement in perceptions of team functioning over time; however the rest of the measures showed no significant improvement. Similar to previous studies, Onyett et al. (2009) suggested external organisational change which could not be controlled for impacted negatively on the results of the study.

Hill et al. (2010) utilised a combined organisational primary intervention in the form of Empowerment scheme alongside an individual primary intervention in the form of psychoeducation. The intervention within the study was the Occupational Stress with mental health Clients in Acute Response (OSCAR) intervention (Hill et al., 2010). This aimed to empower the 19 qualified and non-qualified nurses through group training over the course of two full days training over two weeks to help them manage aggression in the workplace. The intervention empowered workers with skills to work as a team, while also educating them with skills to manage their own stress levels. The results found there was no significant differences over time for participants apart from scoring higher in areas of personal accomplishment on the MBI. Hill et al. (2010) study failed to list reasons for the lack of effectiveness of the intervention and focused more on reporting non-significant findings making comparative interpretation of the results difficult.

Stansfeld et al. (2015) utilised an organisational secondary intervention in the form of risk analysis and management. The study examined the effect of weekly/fortnightly e-learning package for 21 mental health trust managers over the course of a three-month period. Data was collected from employees and their records with 283 in the intervention group versus a no intervention control group containing 67 employees. It also interviewed 11

managers for qualitative report. The only effect on employee wellbeing was in the intervention group in comparison to the control group, but significance wasn't reported. Qualitative themes with regards to the intervention was it was deemed easy to use, relevant to the role, with the support deemed positive, however lack of senior management support was an issue in implementation of intervention training. This study, the same as those by Onyett et al. (2009) and Sharkey and Sharples (2003), suggested uncontrolled NHS organisational factors during the course of their studies impacted on the results in a negative manner.

In summary, of the four organisational and team-based themed interventions which showed a significant level of effectiveness, only Hill et al. (2010) who used a combined organisational primary empowerment scheme intervention alongside an individual primary psychoeducation intervention significantly improved scores on a burnout measure (personal accomplishment on the MBI). Other studies found improvements in different areas. Sharkey and Sharples (2003) significantly reduced stress levels, and Onyett et al. (2009) utilised a group primary team building intervention to significantly improve team working. However, no studies reported long term follow up scores, with Onyett et al. (2009), Sharkey and Sharples (2003) and Stansfeld et al. (2015) reporting NHS organisational factors and changes potentially impacting on their results.

Interventions with evidence of effectiveness.

Of the eighteen studies reviewed, seven did not show any interventions which had any significant effect on reducing occupational stress or burnout for NHS staff (See table 7). However, eleven of eighteen studies reported did show interventions which were significantly effective at reducing scores on various measures for NHS staff (see Table 8).

Table 7.

Studies with no evidence of significant benefits.

Intervention category	Study	Areas of measurement / Measure
INDIVIDUAL	Carson et al. (1999)	No significant difference between social support groups and control.
INDIVIDUAL	Carson (2005)	No significant difference between self-esteem workshop attendees and waitlist in terms of burnout.
INDIVIDUAL	Cottrell (2001)	Presents no data on the nature or effectiveness of the intervention.
INDIVIDUAL	Kanji et al. (2006)	No effect on burnout outcomes in either the autogenic training or the laughter therapy groups in comparison to control waiting list.
TRAINING	Berry et al. (2012)	No significant effect on MBI for staff being taught staff skills to deal with challenging behaviour.
TRAINING	Doyle et al. (2007)	No significant differences between psychosocial intervention training group and control group in terms of burnout.
ORGANISATIONAL	Stansfeld et al. (2015)	No significant effect on reduction in job strain for individuals in group receiving the E-learning package for Mental Health Trust Managers with face-face sessions alongside telephone and email support versus the control group.

Table 8.

Studies with evidence of significant benefits

INTERVENTION CATERGORY	Study	P value	Cohen's <i>d</i>	Areas of measurement / Measure
INDIVIDUAL	Gardner et al. (2005)	0.005	0.81	Significant improvement in employee health and wellbeing.
INDIVIDUAL	Grime (2004)	Depression: 0.028 *Anxiety: 0.021	0.83 1	Significant improvement in employee health and wellbeing.
INDIVIDUAL	Meerten et al. (2011)	EE: <0.001	0.6	Significant improvement in emotional exhaustion on the MBI.
INDIVIDUAL	Michie (1999)	Anxiety: <0.001 Depressed: <0.001	1.8 1.18	Significant improvement in self-developed mood measures
INDIVIDUAL	Reynolds et al. (1993)	GHQ: 0.003	0.32	Significant improvement on health and wellbeing questionnaire.
TRAINING	Ewers et al. (2002)	EE: 0.04 DP: 0.01 PA: 0.01	N/A**	Significant positive change in terms of occupational stress/burnout reduction on all areas of the MBI.
TRAINING	Redhead et al. (2011)	DP: 0.018	1.19	Significant in reducing a sense of depersonalisation on the MBI.
ORGANISATIONAL	Bunce & West (1996)	Sat: <0.05 JIT: <0.05 In: <0.001	N/A 0.4 0.92	Significant positive change in Job satisfaction, Job Induced Tension and Innovation.
ORGANISATIONAL	Hill et al. (2010)	PA: < 0.005	N/A**	Significantly improved sense of personal accomplishment on the MBI.
ORGANISATIONAL	Onyett et al. (2009)	TCI-C: 0.044 TCI-I <0.001 TCI-O: 0.017 TCI-Q: 0.013	0.2 0.4 0.24 0.25	Significantly improved team working.
ORGANISATIONAL	Sharkey & Sharples (2003)	FIJ: <0.05 TMR: <0.05 NSI-W: <0.05 NSI-R: <0.05 NSI-A: <0.05 NSI-P: <0.05 NSI-S: <0.05	0.4 0.34 0.65 0.85 0.67 0.78 0.59	Significant reduction in stress levels.

Note. EE: Emotional Exhaustion, DP: Depersonalisation, PA: Personal Accomplishment.

Sat: Job satisfaction; JIT: Job Induced Tension; In: Innovation

TCI-C: Team Climate Inventory-Communication; TCI-I: TCI-Innovation; TCI-O: TCI-Objectives; TCI-Q: TCI-focus on quality.

FIJ: Factors intrinsic to the job question on sources of stress subscale; TMR: The managerial role question on sources of stress subscale.

NSI-W: Nurse Stress Index - Fluctuations in workload question on work related pressure scale; NSI-R: NSI-Dealing with relatives question on work related pressure scale; NSI-A: NSI-Difficulty dealing with aggressive people question on work related pressure scale; NSI-P: NSI-Difficult patients question on work related pressure scale; NSI-S: NSI-Involvement in life and death situations question on work related pressure scale.

* At 1-month follow-up

** Standard Deviation not reported so incalculable

Overall for the studies with evidence of effective interventions, there was six studies in the ‘individual support’ category, one study in the ‘training staff in therapy skills’ category, and four studies in the ‘organisational and team based interventions’ category. Of these studies, the longest intervention was 20 days (Ewers et al., 2002), with the shortest being only 1.5 days (Bunce & West, 1996). All had small to medium sample sizes for intervention, with sample sizes ranging from 19 participants (Hill et al., 2010) to 114 participants (Meerten et al., 2011). Of those studies that reported dropouts, the average attrition rate ranged from 44% (Bunce & West, 1996) to 25% (Gardner et al., 2005). The number of dropouts resulted in a decrease in the number of participants in what were already small samples, thus making it less representative of the population it was measuring.

The quality of the studies with significantly effective interventions varied. One study was considered globally strong (Ewers et al., 2002) which was a ‘training staff in therapy skills’ intervention. Three were considered globally moderate with two in the ‘individual support’ category (Gardner et al., 2005; Grime, 2004) and one in the ‘training staff in therapy skills’ intervention category (Redhead et al., 2011). Finally, seven were considered globally weak with four in the ‘organisational and team based interventions’ category (Bunce & West, 1996; Hill et al., 2010; Onyett et al., 2009; Sharkey & Sharples, 2003) and three in the ‘individual support’ category (Meerten et al., 2011; Michie, 1996; Reynolds et al., 1993).

Of the studies with significant results, only Bunce and West (1996), Gardner et al. (2005), Grime (2004), Hill et al. (2010), and Reynolds et al. (1993) had longer term follow-ups than just post-intervention. Bunce and West (1996) measured at three months and one year, Gardner et al. (2005) had a three month follow up, Grime (2004) measured at one, three and six months, Hill et al. (2010) measured at one month, while Reynolds et al. (1993) measured at one and three month. This lack of information regarding follow-ups does not allow the review to understand whether the significant interventions had long term

effectiveness and whether they had become embedded within the NHS staff, teams or organisations.

The measures used amongst effective studies were valid, however only Ewers et al. (2002) found significant reduction in burnout across all aspects of the MBI, however effect sizes were not reported. Hill et al. (2010), Meerten et al. (2011) and Redhead et al. (2011) only found significance on individual aspects of the MBI. Gardner et al. (2005), Grime (2004), Michie (1999) and Reynolds et al. (1993) all found large significant effect on improvement in employee health and wellbeing, however where other measures of burnout were used no other significant results were shown, and inferences in the reduction of burnout were minimal. Onyett et al. (2009) produced a significantly small effect of improved team working however the overall measures used had no reliability or validity data to suggest it captured occupational stress reduction adequately. Sharkey and Sharples (2003) found a significantly small to medium effect on reduction in occupational stress levels but only on part of the OSI suggesting there were other aspects their intervention failed to affect. Bunce and West (1996) found a significantly medium effect in reduction of Job Induced Stress.

Examining the effectiveness of results shows that overall, ‘individual support’ interventions featured the most in studies showing significant effectiveness, while ‘team based training’ interventions had the stronger studies with regard to quality and were directly focused on burnout reduction on the MBI. However, in summary, the overall results suggest there is limited evidence for both the immediate and the long-term effectiveness of the workplace interventions reviewed in terms of reducing burnout and occupational stress for NHS staff across all three categories.

NHS issues.

NHS barriers to implementation of interventions.

Several studies identified difficulties with implementing interventions. This included interventions not being supported by management (Berry et al., 2012; Carson et al., 1999), lack of accessibility to computers to partake in the intervention (Grime, 2004), not having time to take part due to reasons such as already working multiple hours of unpaid overtime on a weekly basis (Bunce & West, 1996; Carson et al., 1999; Hill et al., 2010; Michie, 1999), and increased clinical and academic workloads meaning additional intervention work was difficult to maintain for the length of the study (Kanji et al., 2006).

NHS research issues.

Other studies found specific difficulties which potentially impacted on results which researchers could not control. This included major external organisational change during the course of the study (Doyle et al., 2007; Stansfeld et al., 2015; Onyett et al. 2009), personal crisis of participants during the study (Sharkey & Sharples, 2003), researcher delivering intervention to participants they were direct colleagues with (Ewers et al., 2002; Gardner et al., 2005; Bunce & West, 1996), and issues with being able to keep intervention group clinical staff participants from control group clinical staff participants because they worked across the same area (Redhead et al., 2011).

In summary, specific NHS factors could have potentially affected results across studies making it difficult to draw conclusions from their findings.

Discussion

The aim of this review was to explore the different types of interventions used to reduce burnout and occupational stress on staff within the NHS. The specific factors which impact the NHS are contextualised before discussing the summary of interventions examined.

NHS context.

The NHS is a unique organisation as it is the largest employer in the UK and one of the largest employers in the world (NHS Confederation, 2017). Therefore, it is important to recognise that across the studies there were specific NHS issues noted which potentially affected results. As proposed within the reviewed literature, healthcare workers such as those in the NHS experienced increased levels of occupational stress leading to absences from work (CIPD, 2013). It is not stated in the literature reviewed whether this affected quality of care delivered by services or that patient safety was compromised due to the occupational stress and burnout levels in staff, but research suggests this could have been a possibility (Wilkinson, 2015). However, it is noted there are specific difficulties conducting research within the NHS (Marjanovic et al., 2019). This review highlighted several factors including those which impacted the ability of researchers to implement interventions within the NHS and to conduct research within the NHS.

The NHS being a government run organisation can mean there are changes in priorities based on short term political policy changes (Green & Thorogood, 2017) which can impact not only the working practices of staff, but also the research into the effect of interventions as identified by papers within this review. The staffing levels and NHS funding are also varied based on clinical and financial priorities in that particular location where, and in a particular year when the research took place (Exworthy & Mannion, 2016). This can mean managers may not support research as it takes away from clinical time which is a

priority within the NHS as it attempts to deliver high quality service user focused care. Due to lower staffing levels, there are fewer staff available to be participants, and less time for staff to take part in research. The lack of funding priorities for interventions into burnout for staff can also mean that when research is conducted within the NHS, it is done by researchers who are colleagues with the participants where the research is conducted, thus impacting on its perceived validity due to accusations of bias. All these factors were commented on within this review as part of the individual studies limitations which could impact the outcomes of the interventions being examined.

Summary of interventions.

The results of the literature review were considered under three categories: individual support interventions (nine studies), training staff in therapy skills interventions (four studies), and organisational and team-based interventions (five studies).

Of the nine individual support intervention studies there was individual tertiary psychotherapy intervention (four studies), a combined individual secondary supervision support intervention with an organisation secondary workload management intervention (one study), an individual primary cognitive group training intervention (one study), individual primary psychoeducation intervention (one study), a mixed group primary team building and individual secondary support mapping intervention (one study) and a combination of individual psychoeducation intervention and individual relaxation intervention (one study). Of these, five studies had significant results in improving mental and health wellbeing using primary cognitive group training intervention (Gardner et al., 2005), individual tertiary psychotherapy intervention (Grime, 2004; Meerten et al., 2011; Michie, 1999) and a combination of individual psychoeducation and individual relaxation intervention (Reynolds et al., 1993). Only Meerten et al. (2004) showed a significantly large effect on improvement

on the Emotional Exhaustion section of the MBI burnout measures, with the global quality rating of that study as weak.

Of the four studies in the ‘training staff in therapy skills’ category, all four utilised a combined organisational primary empowerment scheme intervention with an individual primary psychoeducation interventions, with only two producing significant results. Redhead et al. (2011) intervention significantly reduced depersonalisation on the MBI, while Ewers et al. (2002) significantly reduced on both the negative aspects of the MBI (depersonalisation and emotional exhaustion) whilst increasing a sense of personal achievement on the MBI. Redhead et al. (2011) had a global quality rating of moderate while the study by Ewers et al. (2002) had one of the best global ratings being one of only two studies in the review with a global rating of strong in terms of quality, and the only one with a strong rating with a significant result.

Of the five Organisational and team-based intervention studies, four showed significantly effective results, however all four were globally rated as weak in terms of quality of study. The combined organisational primary empowerment scheme intervention with an individual primary psychoeducation intervention (one study) improved the sense of personal accomplishment on the MBI (Hill et al., 2010). The group primary team building intervention (one study) significantly small effect on improved team working (Onyett et al., 2009). The individual primary team communication skills intervention (one study) significantly had a small to medium effect on improved scores on the NSI and OSI (Sharkey & Sharples, 2003). The group tertiary therapeutic remedial teamwork intervention had a significantly medium effect on improving Job Induced Tension (JIT) (West & Bunce, 1996). Though four had significantly effective results, the impact specifically on burnout and occupational stress measures was limited to only two studies (Hill et al., 2010; Sharkey &

Sharples, 2003), with those only being significant on parts of those measures (Sharkey & Sharples, 2003).

Overall, there was only one study which showed a significant result showing all round improvements on specific burnout and occupational stress measures (Ewers et al., 2002). However, this study did not report effect sizes and the two studies which attempted to replicate Ewers et al. (2002) intervention's approach showed only limited improvement (Redhead et al., 2011) and no improvement (Doyle et al., 2007). Currently, the evidence examined in this review suggests there is a lack of validity in interventions used to treat burnout and occupational stress as recorded by burnout and occupational stress specific measures. However, there seems to be some promise in examining individual support interventions, and organisational and team based interventions further using higher quality research studies. Both these intervention groups contributed the most significantly effective interventions; however the overall quality was lacking with the majority of studies rated as globally weak, and several lacked focus on burnout and occupational stress specific measures such as the MBI.

Methodological limitations of the included papers.

There were several methodological limitations identified in the included papers. One issue was there were a limited range of interventions covered in the studies within this review, considering the large number of available forms of interventions as shown in Table 1. Also, there was a diverse range of measures used to assess change in burnout and occupational stress, with over 30 different measures used across all 18 papers. This made it difficult to compare results between the different identified studies. There was only a limited number of professions examined within the studies. Though there has been research into burnout in high risk of stress professions (e.g. Accident and Emergency workers and

paramedics) there was no studies returned in the systematic search evidencing published research where these professions had occupational stress or burnout interventions delivered to them. This means the finding of this review may not be applicable to these high risk of stress groups.

There were other recurring issues regarding quality (see Table 5) around study design with small sample sizes across studies, not all studies utilising control groups, and poor separation between intervention groups and control. Similarly, there was a lack of blinding and selection bias with the majority of sampling being convenience sampling with either individuals being self-selecting, or authors selecting participants who were direct colleagues, which can bias the results (Eide & Kahn, 2008). There were also problems with most studies experiencing a large number of individuals who withdrew from interventions part-way through the research meaning results may have been affected. The NHS can be a diverse place to work (Office for National Statistics, 2012) but there was a limited amount of data collected on the participants aside from gender (mainly female) and age, which suggested that confounders were not dealt with reducing the quality of studies further. These issues culminated with, out of 18 studies, only two studies receiving a global quality rating of strong and ten receiving a global quality rating of weak.

Potential biases in the review process.

In the grey literature there were several mentions of different interventions used which had either been developed internally or adapted for use with NHS staff (Whitmore et al., 2018), however the exclusion of this literature from the review meant some potentially effective studies were omitted from the analysis. Categorisations of interventions were individualised to how the author felt they fitted best due to a lack of standardised method of organising interventions. Other papers (Dreison et al., 2018; Johnson et al., 2018) used

elements of similar categorisation systems however they may have selected to name the interventions differently to the author when assessing the studies selected for this review. The small number of studies reviewed in this paper and the information provided potentially negates the reviews findings having a major impact.

Theoretical and clinical implications.

There are several theoretical and clinical implications from conducting this review, however these are limited by the findings of minimal evidence for effectiveness of these interventions which impact occupational stress and burnout. The lack of evidence from high quality research for effective interventions for burnout suggests that NHS staff are a difficult to treat group which has been found with doctors, and by proxy other healthcare professionals, sometimes making the worst patients (Klitzman, 2008). This may be due to the staff group, or it could be the execution of trying to implement occupational stress and burnout interventions in NHS settings, however developing interventions for this group may require extensive formulation before attempting execution in order to be effective.

The findings of this review suggest for the conceptualisation of burnout there are theoretical implications. Though there are previously stated limitations for the studies, the effectiveness at reducing burnout from all three categories of interventions suggest burnout can potentially be managed in NHS staff with further development of interventions. This suggests burnout can be approached via a three pronged attack aimed at the individual level, while also training staff in therapy skills, and through team based and organisational intervention methods. The job-demands resource (JD-R) model suggests burnout occurs when an individual feels too much is being demanded of their time and they do not have the resources to manage those demands (Bakker & Demerouti, 2007). The findings of this literature review suggest 'individual support' interventions can target an individual staff

member feeling they are being demanded of too much, with ‘training staff in therapy skills’ and ‘organisational and team based’ interventions focusing on helping staff feel they have the resources to manage those demands. Similarly, the Conservation of Resources (COR) model suggests that persistent threats to available resources and the moves to maintain those resources can lead to burnout (Marek, Schaufeli & Maslach, 2017). A theoretical combined intervention approach using all three categories of intervention could be effective at managing burnout as defined by the COR model. By targeting how an individual manages, and through teaching staff therapeutic skills, staff members can support one another and themselves. The team based and organisational approach could help develop a method of ensuring that resources are managed appropriately thus helping reduce burnout in NHS staff.

Though there is no clear intervention which is most effective, most studies which reported significantly effective results utilised evidence-based interventions. This suggests the insertion of evidence-based therapies from the National Institute for Health and Care Excellence (NICE) (2017) guidelines for managing workplace stress (as Burnout is not a recognised diagnosis by NICE) such as CBT could potentially provide an effective intervention. However, this is difficult to determine from the review as different studies used different evidence-based interventions.

Finally, the review only found 18 studies across a 30-year period. This fact combined with the continued reported prevalence of occupational stress and burnout suggests that occupational stress and burnout interventions are not being delivered or are not being delivered effectively across the NHS. This suggests that delivering interventions in the NHS and recording their delivery in a rigorous way so they may be published in an academic journal is infrequent. Therefore the barriers that may be context specific to delivering interventions in the NHS should be acknowledged before implementation (Marjanovic et al.,

2019). This could potentially increase both the likelihood of effectiveness in impacting occupational stress and burnout, but also the likelihood of disseminating the results.

Implications for research.

Following the lack of clarity around effective interventions identified in this literature review, further quality research is required which investigates what interventions could be most useful at reducing burnout and occupational stress for staff within the NHS. Of the studies identified, only two had a quality assessment of strong, with ten studies identified as having an overall global rating of weak. The higher quality studies rated strong globally were RCT's which utilised valid measures (e.g. the MBI), larger sample groups which identified their participants potential confounding demographics and how they dealt with them. More research following these studies principles would be welcomed in this area.

Culture change in the NHS is notoriously hard (Allcock et al., 2015). The limited amount of studies in this review with long-term follow-ups limits the ability to understand the long-term impact of interventions on staff culture. Therefore more studies with long-term follow ups (e.g. 6 months to a year) would be a positive addition to future research studies. The NHS is under pressure financially to reduce costs (Iacobucci, 2017), however none of the studies reviewed provided an analysis of the cost effectiveness of their proposed burnout and occupational stress interventions. As such, it is important for any new research to provide the cost of implementing an intervention so other NHS services understand this before attempting to replicate it. Different staff groups and different shift patterns can be impacted by burnout and occupational stress differently (Wilkinson, 2015) therefore better collection of general demographic data (including job role, gender, hours worked, level of experience) is suggested. There is a current lack of evidence for any one singular intervention amongst the multitude shown in the studies which have been reviewed. Therefore it is suggested

further research should aim to find not only an effective intervention but be able to replicate that interventions effectiveness across different NHS services and staff groups.

Conclusion.

This review has shown what published interventions exist for managing occupational stress and burnout in NHS staff. It has also shown that though some studies interventions have been significantly effective at reducing burnout, with ‘training staff in therapy skills’ interventions showing some of the stronger results in higher quality studies, the overarching theme of the studies which have been reviewed suggest there is a current lack of effective interventions and it is difficult to reduce burnout in this population. This may be due to the various limitations identified in both this review and the studies within this review. This currently makes it difficult to determine the exact nature of what the most effective interventions for managing occupational stress and burnout in NHS staff are. However there is scope for higher quality research to be conducted in the future examining ‘individual support’ interventions and ‘organisational and team-based’ interventions as several had significant results but were published in globally weak quality studies. This review highlights that there is a need to conduct more higher quality long term research, into what interventions could work with this population, while factoring in the unique context of working within the NHS. This is important as effective interventions of occupational stress and burnout could have a positive impact on both the mental wellbeing for a large number of employed individuals within the UK, and thus on the level of healthcare provided to the UK public in general.

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[events/latest-news/narrowing-of-nhs-gender-divide-but-men-still-the-majority-in-senior-roles](https://digital.nhs.uk/news-and-events/latest-news/narrowing-of-nhs-gender-divide-but-men-still-the-majority-in-senior-roles)

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Literature review appendices index

Appendix A – Research database intervention definition

Appendix B – Systematic search including intervention as search term

Appendix C – Medline systematic search

Appendix D – PsycINFO systematic search

Appendix E – Web of Science systematic search

Appendix F – CINAHL systematic search

Appendix A – Research database intervention definition

Results For: INTERVENTION		Explode (+)	Major Concept	Scope
<input type="checkbox"/>	Crisis Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Early Intervention (Education)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Percutaneous Coronary Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Early Medical Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Genetic Engineering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Medical Intervention, Early Use: Early Medical Intervention			
	Intervention, Percutaneous Coronary Use: Percutaneous Coronary Intervention			
	Intervention, Genetic Use: Genetic Engineering			
	Intervention, Early Medical Use: Early Medical Intervention			
	Intervention, Early (Education) Use: Early Intervention (Education)			
	Intervention, Early Use: Early Intervention (Education)			
	Intervention, Crisis Use: Crisis Intervention			
	Intervention Study Use: Clinical Trial			
	Genetic Intervention Use: Genetic Engineering			
	Early Intervention Use: Early Intervention (Education)			
<input type="checkbox"/>	INTERVENTION (Search as keyword) ?			

Appendix B – Systematic search including intervention as search term

Items selected: 14 <input checked="" type="checkbox"/> Delete Save Show all details Export all searches ▼				Saved searches (15)	
<input checked="" type="checkbox"/>	Set ▲	Search	Databases	Results	Actions
<input checked="" type="checkbox"/>	S1	<input type="checkbox"/> MJMAINSUBJECT.EXACT.EXPLODE("Medical Personnel") Limits applied	PsycINFO	40,797	Actions ▼
<input checked="" type="checkbox"/>	S2	<input type="checkbox"/> MJMAINSUBJECT.EXACT.EXPLODE("Health Personnel") OR MJMAINSUBJECT.EXACT.EXPLODE("Allied Health Personnel") OR MJMAINSUBJECT.EXACT.EXPLODE("Mental Health Personnel") Limits applied	PsycINFO	78,970	Actions ▼
<input checked="" type="checkbox"/>	S3	<input type="checkbox"/> "health service worker*" OR "healthcare personnel" OR "health care worker*" OR "healthcare worker*" OR "health workers" OR "health professional*" OR "healthcare professional*" OR "medical care personnel" OR "healthcare staff" OR "healthcare professional*" OR "mental health care worker*" OR "mental healthcare worker*" OR "mental health worker*" OR "mental health professional*" OR "mental healthcare professional*" OR "mental healthcare staff" OR "mental health nurse" OR "Psychiatric healthcare personnel" OR "Psychiatric health care worker*" OR "psychiatric healthcare worker*" OR "psychiatric health worker*" OR "psychiatric health professional*" OR "psychiatric healthcare professional*" OR "psychiatric staff" OR "Psychiatric nurse" OR "nurs*" OR "physician" OR "psychologist" OR "psychiatrist" OR "social worker*" OR "occupational therapist*" OR "counselor*" OR "Doctor*" OR "therapist" OR "pharmacist*" OR "paramedic*" OR "Dentist*" OR "radiographer*" OR "cardiographer*" OR "manager*" OR "management" OR "medical technician*" OR "adminin*" Limits applied	PsycINFO	570,028	Actions ▼
<input checked="" type="checkbox"/>	S4	<input type="checkbox"/> S1 OR S2 OR S3	PsycINFO	589,870	Actions ▼
<input checked="" type="checkbox"/>	S5	<input type="checkbox"/> "National Health Service" OR NHS Limits applied	PsycINFO	20,771	Actions ▼
<input checked="" type="checkbox"/>	S6	<input type="checkbox"/> MAINSUBJECT.EXACT.EXPLODE("Occupational Stress") Limits applied	PsycINFO	13,124	Actions ▼
<input checked="" type="checkbox"/>	S7	<input type="checkbox"/> "Job stress" OR "Burnout" OR "burn out" Limits applied	PsycINFO	11,042	Actions ▼
<input checked="" type="checkbox"/>	S8	<input type="checkbox"/> ((occupational OR work OR worker* OR working OR workplace OR worksite OR job*) AND (stress OR strain OR anxiety OR depressive OR depression OR burden)) Limits applied	PsycINFO	84,077	Actions ▼
<input checked="" type="checkbox"/>	S9	<input type="checkbox"/> S6 OR S7 OR S8	PsycINFO	86,577	Actions ▼
<input checked="" type="checkbox"/>	S10	<input type="checkbox"/> S4 AND S5 AND S9	PsycINFO	694	Actions ▼
<input checked="" type="checkbox"/>	S11	<input type="checkbox"/> lo.Exact("Wales" OR "England" OR "United Kingdom" OR "Scotland" OR "Northern Ireland") Limits applied	PsycINFO	103,354	Actions ▼
<input checked="" type="checkbox"/>	S13	<input type="checkbox"/> S10 AND S11 Limits applied	PsycINFO	352*	Actions ▼
<input checked="" type="checkbox"/>	S14	<input type="checkbox"/> MJMAINSUBJECT.EXACT.EXPLODE("Workplace Intervention") Limits applied	PsycINFO	260*	Actions ▼
<input checked="" type="checkbox"/>	S15	<input type="checkbox"/> S14 AND S13	PsycINFO	0*	Actions ▼

Appendix C – Medline systematic search

Search History/Alerts

Print Search History Retrieve Searches Retrieve Alerts Save Searches / Alerts

Select / deselect all **Search with AND** **Search with OR** **Delete Searches** **Refresh Search Results**

Search ID#	Search Terms	Search Options	Actions
<input type="checkbox"/> S11	S6 AND S7 AND S9	<p>Limiters - Date of Publication: 1980/01+; English Language</p> <p>Narrow by SubjectGeographic: - wales</p> <p>Narrow by SubjectGeographic: - scotland</p> <p>Narrow by SubjectGeographic: - united kingdom</p> <p>Narrow by SubjectGeographic: - london</p> <p>Narrow by SubjectGeographic: - england</p> <p>Search modes - BooleanPhrase</p>	<p>View Results (122) View Details Edit</p>
<input type="checkbox"/> S10	S6 AND S7 AND S9	<p>Limiters - Date of Publication: 1980/01+; English Language</p> <p>Search modes - BooleanPhrase</p>	<p>View Results (1,015) View Details Edit</p>
<input type="checkbox"/> S9	S1 OR S8	<p>Search modes - BooleanPhrase</p>	<p>View Results (2,411,371) View Details Edit</p>
<input type="checkbox"/> S8	AB "health service worker" or "healthcare personnel" or "health care worker" or "healthcare worker" or "health worker" or "health workers" or "health professional" or "healthcare professional" or "medical care personnel" or "healthcare staff" or "mental health care personnel" or "mental health care worker" or "mental healthcare worker" or "mental health worker" or "mental health professional" or "mental healthcare professional" or "mental healthcare staff" "mental health nurse" or "Psy ...	<p>Limiters - Date of Publication: 1980/01+; English Language</p> <p>Search modes - BooleanPhrase</p>	<p>View Results (2,154,463) View Details Edit</p>
<input type="checkbox"/> S7	"National Health Service" OR NHS	<p>Search modes - BooleanPhrase</p>	<p>View Results (143,434) View Details Edit</p>
<input type="checkbox"/> S6	AB S2 OR S3 OR S4 OR S5	<p>Limiters - Date of Publication: 1980/01+; English Language</p> <p>Search modes - BooleanPhrase</p>	<p>View Results (164,036) View Details Edit</p>
<input type="checkbox"/> S5	(occupational OR work OR worker OR working OR workplace OR worksite OR job) AND (stress OR strain OR anxiety OR depressive OR depression OR burden)	<p>Search modes - BooleanPhrase</p>	<p>View Results (179,909) View Details Edit</p>
<input type="checkbox"/> S4	"job stress" or "Burnout" or "burn out"	<p>Search modes - BooleanPhrase</p>	<p>View Results (16,647) View Details Edit</p>
<input type="checkbox"/> S3	(MM "Stress, Occupational")	<p>Search modes - BooleanPhrase</p>	<p>View Results (25,789) View Details Edit</p>
<input type="checkbox"/> S2	(MM "Burnout, Professional")	<p>Search modes - BooleanPhrase</p>	<p>View Results (7,926) View Details Edit</p>
<input type="checkbox"/> S1	(MM "Health Personnel") OR (MM "Mental Health Personnel") OR (MM "Allied Health Personnel") OR (MM "Occupational Health Services")	<p>Search modes - BooleanPhrase</p>	<p>View Results (361,537) View Details Edit</p>

Appendix D – PsycINFO systematic search

Items selected: 0		Delete	Save	Show all details	Export all searches	Saved searches (15)		
<input type="checkbox"/>	Set	Search	Databases	Results	Actions			
<input type="checkbox"/>	S1	MJMAINSUBJECTEXACTEXPLODE("Medical Personnel") ✓ Limits applied	PsycINFO	40,797	Actions			
<input type="checkbox"/>	S2	MJMAINSUBJECTEXACTEXPLODE("Health Personnel") OR MJMAINSUBJECTEXACTEXPLODE("Allied Health Personnel") OR MJMAINSUBJECTEXACTEXPLODE("Mental Health Personnel") ✓ Limits applied	PsycINFO	78,970	Actions			
<input type="checkbox"/>	S3	"health service worker*" OR "healthcare personnel" OR "health care worker*" OR "healthcare worker*" OR "health worker*" OR "health workers" OR "health professional*" OR "healthcare professional*" OR "medical care personnel" OR "healthcare staff" OR "mental healthcare professional*" OR "mental health care worker*" OR "mental healthcare worker*" OR "mental health worker*" OR "mental health professional*" OR "mental healthcare professional*" OR "mental healthcare staff" OR "mental health nurse" OR "Psychiatric healthcare personnel" OR "Psychiatric health care worker*" OR "psychiatric healthcare worker*" OR "psychiatric health worker*" OR "psychiatric health professional*" OR "psychiatric healthcare professional*" OR "psychiatric staff" OR "psychiatric nurse" OR "nurs*" OR "physician*" OR "psychologist*" OR "psychiatrist*" OR "social worker*" OR "occupational therapist*" OR "counselor*" OR "Doctor*" OR "therapist*" OR "pharmacist*" OR "paramedic*" OR "Dentist*" OR "radiographer*" OR "cardiographer*" OR "manager*" OR "management" OR "medical technician*" OR "admin*" ✓ Limits applied	PsycINFO	570,028	Actions			
<input type="checkbox"/>	S4	S1 OR S2 OR S3	PsycINFO	589,870	Actions			
<input type="checkbox"/>	S5	"National Health Service" OR NHS ✓ Limits applied	PsycINFO	20,771	Actions			
<input type="checkbox"/>	S6	MAINSUBJECTEXACTEXPLODE("Occupational Stress") ✓ Limits applied	PsycINFO	13,124	Actions			
<input type="checkbox"/>	S7	"Job stress" OR "Burnout" OR "burn out" ✓ Limits applied	PsycINFO	11,042	Actions			
<input type="checkbox"/>	S8	((occupational OR work OR worker* OR working OR workplace OR worksite OR job*) AND (stress OR strain OR anxiety OR depressive OR depression OR burden)) ✓ Limits applied	PsycINFO	84,077	Actions			
<input type="checkbox"/>	S9	S6 OR S7 OR S8	PsycINFO	86,577	Actions			
<input type="checkbox"/>	S10	S4 AND S5 AND S9	PsycINFO	694	Actions			
<input type="checkbox"/>	S11	!o.Exact("Wales" OR "England" OR "United Kingdom" OR "Scotland" OR "Northern Ireland") ✓ Limits applied	PsycINFO	103,354	Actions			
<input type="checkbox"/>	S13	S10 AND S11 ✓ Limits applied	PsycINFO	352	Actions			

Appendix E – Web of Science systematic search

Search History:		Save History / Create Alert		Open Saved History		Combine Sets		Delete Sets	
Set	Results					Edit Sets	AND OR	Select All	Delete
# 11	335	(#8 AND #7 AND #4) AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Refined by: COUNTRIES/REGIONS: (ENGLAND OR SCOTLAND OR WALES OR NORTH IRELAND) AND DOCUMENT TYPES: (ARTICLE) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input checked="" type="checkbox"/>
# 10	335	(#8 AND #7 AND #4) AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Refined by: COUNTRIES/REGIONS: (ENGLAND OR SCOTLAND OR WALES OR NORTH IRELAND) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input checked="" type="checkbox"/>
# 9	393	(#8 AND #7 AND #4) AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Edit		<input type="checkbox"/>	<input checked="" type="checkbox"/>
# 8	21,487	(TS=("National Health Service" OR NHS)) AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edit		<input type="checkbox"/>	<input type="checkbox"/>
# 7	335,450	#6 OR #5 Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edit		<input type="checkbox"/>	<input type="checkbox"/>
# 6	325,103	TS=(("occupational OR work OR worker" OR working OR workplace OR worksite OR job*) AND (stress OR strain OR anxiety OR depressive OR depression OR burden)) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edit		<input type="checkbox"/>	<input type="checkbox"/>
# 5	19,562	TS=(("Job stress" OR Burnout OR "burn out")) AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edit		<input type="checkbox"/>	<input type="checkbox"/>
# 4	2,733,010	(#3 OR #2 OR #1) AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edit		<input type="checkbox"/>	<input type="checkbox"/>
# 3	1,622	TS=(("healthcare staff" OR "mental healthcare personnel" OR "mental health care worker*" OR "mental healthcare worker*" OR "mental health worker*" OR "mental healthcare staff" OR "psychiatric healthcare personnel" OR "Psychiatric health care worker*" OR "psychiatric healthcare worker*" OR "psychiatric staff") AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edit		<input type="checkbox"/>	<input type="checkbox"/>
# 2	2,718,742	TS=(("health professional*" OR "mental health professional*" OR "healthcare professional*" OR "medical care personnel" OR "psychiatric healthcare professional*" OR "psychiatric health professional*" OR "psychiatrist" OR "social worker*" OR "occupational therapist" OR "counselor" OR "therapist" OR "pharmacist" OR "paramedic" OR "dentist" OR "radiographer" OR "cardiographer" OR "manager" OR "management" OR "medical technician*" OR "admin*") AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edit		<input type="checkbox"/>	<input type="checkbox"/>
# 1	30,263	TS=(("health personnel" OR "allied health personnel" OR "medical personnel" OR "Mental health personnel" OR "health service worker*" OR "healthcare personnel" OR "health care worker*" OR "healthcare worker*" OR "health workers") AND LANGUAGE: (English) AND DOCUMENT TYPES: (Article) Indexes=SCI-EXPANDED, SSCI, A&HCI, CPPI-S, CPPI-SSH, ESCI Timespan=1989-2019	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edit		<input type="checkbox"/>	<input type="checkbox"/>

Appendix F – CINAHL systematic search

Search History/Alerts

[Print Search History](#) [Retrieve Searches](#) [Retrieve Alerts](#) [Save Searches / Alerts](#)

<input type="checkbox"/> Select / deselect all		<input type="button" value="Search with AND"/> <input type="button" value="Search with OR"/> <input type="button" value="Delete Searches"/>		<input type="button" value="Refresh Search Results"/>	
Search ID#	Search Terms	Search Options	Actions		
<input type="checkbox"/> S1	(MM "Health Personnel") OR (MM "Mental Health Personnel") OR (MM "Allied Health Personnel") OR (MM "Occupational Health Services")	Search modes - BooleanPhrase	View Results (307,187) View Details Edit		
<input type="checkbox"/> S2	(MM "Burnout, Professional")	Search modes - BooleanPhrase	View Results (5,884) View Details Edit		
<input type="checkbox"/> S3	(MM "Stress, Occupational")	Search modes - BooleanPhrase	View Results (13,890) View Details Edit		
<input type="checkbox"/> S4	*Job stress* or "Burnout" or "Burn out"	Search modes - BooleanPhrase	View Results (12,014) View Details Edit		
<input type="checkbox"/> S5	(occupational OR work OR worker OR working OR workplace OR worksite OR job) AND (stress OR strain OR anxiety OR depressive OR depression OR burden)	Search modes - BooleanPhrase	View Results (57,754) View Details Edit		
<input type="checkbox"/> S6	AB S2 OR S3 OR S4 OR S5	Limiters - Published Date: 1980/01; English Language	View Results (61,214) View Details Edit		
		Search modes - BooleanPhrase			
<input type="checkbox"/> S7	"National Health Service" OR NHS	Search modes - BooleanPhrase	View Results (32,208) View Details Edit		
<input type="checkbox"/> S8	AB "health service worker" or "healthcare personnel" or "health care worker" or "healthcare worker" or "health worker" or "health workers" or "health professional" or "healthcare professional" or "medical care personnel" or "healthcare staff" or "mental healthcare personnel" or "mental health care worker" or "mental healthcare worker" or "mental health worker" or "mental health professional" or "mental healthcare professional" or "mental healthcare staff" "mental health nurse" or "Psy ...	Limiters - Published Date: 1980/01; 2019/231; English Language	View Results (757,006) View Details Edit		
		Search modes - BooleanPhrase			
<input type="checkbox"/> S9	S1 OR S8	Search modes - BooleanPhrase	View Results (1,019,898) View Details Edit		
<input type="checkbox"/> S10	S6 AND S7 AND S9	Limiters - Published Date: 1980/01; English Language; Peer Reviewed	View Results (370) View Details Edit		
		Narrow by SubjectGeographic: - uk & ireland			
		Search modes - BooleanPhrase			

Section 3: Empirical Paper

*An Exploration Of Nurses' Perceptions Of Special Measures and How
It Impacts Working Within Adult Mental Health Inpatient Services Under
Special Measures*

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Declaration of Conflicting Interests

The authors declare that there is no conflict of interests.

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Abstract

Introduction: Public funded organisations that are deemed to provide inadequate quality of public services are allocated the status of being placed into ‘special measures’ to improve them. However little is known about how organisational changes like special measures impact on front line staff. This qualitative study aimed to examine adult Inpatient Mental Health (IMH) nurses’ perspectives on how special measures has impacted on their experience of working in an organisation in special measures.

Methods: Semi-structured interviews were conducted with ten IMH nurses who had experience of working for a Health Board that had been under special measures. Thematic Analysis was used to explore how adult IMH nurses perceive special measures to have impacted on their experience of working in an organisation under special measures.

Results: The analysis produced a singular main theme of *Special measures confusion*, which permeated the three key themes with related sub themes: *Isolated and powerless*, *Opportunity costs*, and *Adapt to survive*.

Conclusions: The findings highlighted the complexity of understanding what it is like to work under special measures, and the impact it has on IMH nurses. Further research is required to understand the experiences of others working under special measure, and its long-term impact on staff.

Keywords: *Inpatient, mental health, nurse, national health service, special measures.*

Introduction

Government funding of the public sector has meant there has always been extra scrutiny of public services ability to provide high quality services and therefore an increased level of public accountability compared to private sector organisations (Bovaird & Löffler, 2009). In recent years for public funded organisation or services that have repeatedly failed to improve the quality of its services, despite the application of multiple quality improvement interventions sometimes over timescales of several years, has meant the organisation or service are allocated the status of being placed into ‘special measures’.

Monitor, which is a part of National Health Service (NHS) Improvement, provide this definition of special measures (Monitor, 2014, p.2): “Special measures apply to NHS trusts and foundation trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support. Special measures consist of a set of specific interventions designed to improve the quality of care within a reasonable time. In this approach the Care Quality Commission (CQC) will focus on identifying failures in the quality of care and judging whether improvements have been made. The NHS Trust Development Authority (NHS TDA) and Monitor will use their respective powers to support improvement in the quality of care provided.”

Public services in special measures are expected to be monitored externally, provided with a framework of how to improve through working with other successful organisations, and be given a timeframe in which to achieve these improvements (Care Quality Commission (CQC), 2015). Services failing to make improvements are then either shut down or taken over by another organisation.

Even though there has been monitoring of public services in various forms since their inception and is part of public services core values to consistently strive to improve quality of services to the public, the use of the term ‘special measures’ to define a form of organisational intervention to bring about organisational improvement is a recent occurrence. The first noted use of special measures being placed on a service within the public sector was on schools following the formation of the Office for Standards in Education (OFSTED) in 1992 (Scanlon, 1999). Schools who had not managed to improve within a requested timeframe despite multiple organisational interventions were placed under special measures and were expected to improve standards in areas requested by inspectors or face closure or radical reorganisation. Bubb and Earley (2009) suggest special measures helps leaders to improve their schools and to continue to improve after special measures status has been removed. However, a review of the literature on the impact of the further inspection and raising of standards inspectors expect, has suggested it may merely lead to further difficulties in schools improving standards (Klerks, 2013). Willis’s (2010) study examining special measures in schools is an example of the lack of understanding on the impact for front line staff who are placed in charge of bringing about change. Willis (2010) found special measures can impact the culture of a school in several ways, mainly positive in improving services, but one of which can mean it is difficult to implement leadership strategies and creates an atmosphere of distrust which can linger long after special measures has been achieved and can lead to future problems in delivering high quality services. However the same paper also found two out of three headteachers interviewed considered special measures to be a positive intervention.

The relationship between special measures and organisational culture is nuanced and complex. Organisational culture can have a strong impact on whether an organisation functions appropriately or problematically. In organisations where there is a problematic

organisational culture, intervention may be required. Large scale organisational change interventions which are implemented to improve services can impact on several areas of an organisation, with one of these areas being the culture of an organisation. In the context of special measures as an organisational change intervention, the ultimate purpose is to improve the quality of patient care and part of how this is done is through bringing about organisational cultural change. For instance, the McKinsey Hospital Institute (2015) suggests the culture of an NHS organisation can lead to difficulties (e.g. problematic staff culture can lead to patient care being impacted negatively) within NHS trusts which in turn can lead to an NHS trust requiring allocation of special measures. Special measures is considered a final resort after multiple other interventions have been attempted to improve the organisation in question in terms of quality of patient care. Following the introduction of special measures, it can create organisational change which can lead to changes in organisational culture with the purpose of ultimately improving the quality of patient care (McKinsey Hospital Institute, 2015).

However, as found by Willis (2010) in schools, there is potential for implemented large scale organisational change such as special measures to have a negative impact, even in the short term, which can lead to difficult working conditions for staff and a poorer service being delivered during implementation periods. Therefore, it is important to identify how to ensure that services maintain and improve during this implementation process if detrimental effects are potentially being felt so those individuals receiving a service are not affected negatively. This would be to ensure that if short-term difficulties were to occur, they would not hinder the goal of long-term improvement, which for those in the NHS mean safeguarding continued improvement in quality of patient care.

As stated in the NHS constitution, a core principle of the NHS both currently and historically is to continually improve the quality of services in all areas of the NHS

(Department of Health and Social Care, 2015). This principle is applied throughout the NHS across the UK including Wales (NHS Wales, 2019). However, following the reported failures found within the Mid-Staffordshire NHS Foundation Trust enquiry (The Francis (2013) report), further more drastic measures were recommended for improving trusts which were failing to improve, and in problematic circumstances. This led to the first use of special measures in healthcare being applied to several trusts, health boards, and other sections of the NHS. This took the form of either being placed either into financial special measures (due to a Trust being in serious financial difficulty), or into special measures for quality (due to receiving an inadequate rating in one or more areas of the trust which leadership has not been able to rectify) (BMA, 2017). The ultimate aim of both these forms of special measures being implemented was to improve the organisation to be able to deliver high quality patient care. How special measures works in practice can vary across different nations and regions. For example, special measures for the NHS in Wales is the process which adds extra overview of a Health Board's practices and management by Welsh Government officials, Welsh Audit Office and the Healthcare Inspectorate Wales (Welsh Government, 2017). Betsi Cadwaladr University Health Board (BCUHB) was placed into special measures in 2015 in relation to the NHS Wales escalation framework following discussions between these bodies, with five key areas identified for tangible improvement (BCUHB, 2019): Governance, leadership and oversight; Maternity services; GP and primary care services including out of hours services; Reconnecting with the public and regaining the public's confidence; and mental health services.

There has been minimal research in the area of special measures within the NHS, though CQC (2014) reports suggest special measures as an organisational intervention to improve quality of patient care has been successful, at least in the short term, for trusts and health boards placed under special measures. However, the lack of studies on the effect of

special measures on staff suggests the key personnel delivering changes to clients is a missing voice within the literature.

The topic of special measures is particularly relevant, with several NHS organisations currently being in special measures, with several within Wales (Morris, 2018). Though special measures has brought about improvements in the rating of different healthcare providers and thus the quality of its patient care (CQC, 2014), large scale organisational change could also potentially be considered an additional stressor on the workforce (Kelliher & Parry, 2015). This, alongside other factors, has meant a different and potentially high-pressure working environment which could work against the aim of special measures improving the quality of patient care if staff are impacted negatively. For example, within the NHS, there has already been a decrease in funding in line with inflation, decreases in staff numbers and in the number of beds within inpatient units, combined with an increase in demand of the service (Fanneran, Brimblecome, Bradley & Gregory, 2015). For those working within a service in special measures, the added pressure of extra outside inspection can also mean further media scrutiny which can lead to staff worrying more about their actions becoming headline news (Oliver, 2016). However, the concept of additional media coverage of an organisation making positive changes to improve patient healthcare services could be considered a beneficial public relation exercise which improves the standing of the organisation in the eyes of stakeholders (Leask, Hooker & King, 2010).

The staff within an NHS organisation are the individuals tasked with delivering high quality patient care, however stress can have a significant impact on a healthcare workers ability to deliver this (Mosadeghrad, 2014). Problematically, working within mental health has been shown to be stressful (Salyers et al., 2015). There are around 200,000 people employed to care for people with mental health difficulties, with nurses being the largest professional group making up around 20% of the workforce, however their numbers are in

decline (NHS Digital, 2018). Campbell (2016) suggests front line staff's role requires them to be both physically and psychologically capable. However, any particular additional stressor, such as large organisational change, can potentially impact on their ability to provide adequate care for their patients. This means stress affecting this specific population could have a significant detrimental effect on the service (Hunsaker, Chen, Maughan & Heaston, 2015). Yet, it should also be noted that the benefits of improved services through large organisational change such as special measures which are able to deliver high quality patient care could mitigate the stress nurses experience, thus having a positive impact on the overall service (Glaser et al., 2015).

Many mental health nurses working within inpatient mental health (IMH), as well as staff working across the NHS, must be able to manage individuals in high levels of distress who are actively attempting to self-harm or end their lives (Halter, 2017). IMH nurses also report difficulties in multi-tasking such as managing admissions, medication protocols, incident forms, and ward rounds while trying to provide one to one care, all with limited number of staff (Fanneran-Hamilton, Bradley & McNally, 2017). It is suggested by Townsend and Morgan (2017) that this causes heightened levels of stress for those working in these environments in comparison to other areas of mental health work. Therefore it is amongst IMH nurses where the effects of the implementation of large-scale organisational change (such as special measures) on front line staff could be understood.

The importance of improving NHS services so they deliver high quality patient care is paramount and a core value which the NHS strives to consistently work upon. Understanding how a serious organisational intervention such as special measures is perceived by staff, and how it is perceived to impact on the work staff do is important as this perception can aid or inhibit the individuals who are tasked with delivering high quality patient care. Therefore the

aim of this research is to examine adult IMH nurses' perspectives on how special measures has impacted on their experience of working in an organisation in special measures.

Method

Study design.

A qualitative methodology was chosen for this project as it could reveal new information regarding adult IMH nurses' perspectives on how special measures has impacted on their experience of working in an organisation in special measures. Qualitative methods could provide a rich level of data surrounding participants beliefs, thoughts and motivations while potentially providing an understanding of the complex relationship between these areas. This could be critical to understanding what adult IMH nurses' perspectives are on how special measures has impacted on their experience of working in an organisation in special measures. Individual interviews were selected over focus groups as to allow participants to speak freely knowing data collected would be kept confidential. Individual interviews also allowed a richer level of data to be collected in comparison to other methods such as questionnaires, but a more individual confidential version of events than if the data was collected via focus groups.

Thematic Analysis (TA) was selected as the chosen qualitative methodology of this study for several reasons which are described in Braun and Clarke (2006). This includes the suggestion that TA is considered a useful methodology to utilise when the topic is exploratory. At the time of writing, there is no previous research exploring adult IMH nurses' perspectives on how special measures has impacted on their experience of working in an organisation in special measures, and therefore fits the criteria of an exploratory project in terms of TA. Braun and Clarke (2006) suggest TA is considered a methodology which allows flexibility in the selection of a projects epistemology while offering an established method to analyse the data. TA aims to represent as objectively as is possible within qualitative research the targeted topic that is being explored. As such, the TA method suits the current project

where the researcher wishes to limit the amount the researcher's own interpretations may impact on the participants' representations, and aims to produce themes which summarise as closely as possible what participants have said which was a key priority for the project. It therefore differs from methods where the researchers interpretations are critical to the method such as in Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2008). Other methods such as Grounded Theory (GT) were rejected as the focus of this research was not on providing a model to explain the topic (Charmaz, 2014) but exploring participants perceptions on how special measures may have impacted working as an adult IMH nurse in a service in special measures. In summary, TA was deemed the most appropriate method to provide an answer to the research question through how it communicates results and offers a comprehensive understanding of the meaning of the phenomena being examined.

This study chose a contextualistic critical realist epistemological stance informed by critical realism to understand participants' experiences as this recognises that individuals' perceptions are moulded by and positioned in different contexts yet can still embody the individual participants' truth (Braun & Clarke, 2006). Braun and Clarke (2006) state that "thematic analysis can be a 'contextualist' method sitting between the two poles of essentialism and constructionism, characterised by theories such as critical realism (e.g. Willig, 1999), which acknowledge the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of reality" (p. 9). Therefore, as articulated by Braun and Clarke (2006), TA can be a method that works both to reflect reality and to unpick or unravel the surface of reality.

Participants.

Mental health nurses who worked in adult acute inpatient mental health services were recruited via convenience sampling from adult acute psychiatric inpatient units across North Wales between December 2018 and March 2019 to participate in the study. Convenience sampling was utilised to recruit individuals to the study. Potential participants were purposefully approached by the lead researcher to take part in the study based on the inclusion criteria that they were: (1) qualified IMH nurses, (2) who had experience of working on an adult IMH ward, (3) that was under special measures. Potential IMH nurse participants were identified through the lead researcher (DM) going on to adult IMH wards across the service which was under special measures and speaking to those adult IMH nurses who were on duty during that shift. This meant potential participants who were approached would always fit the inclusion criteria and therefore the sample consisted of those who were conveniently accessible on the ward. The majority of potential participants approached took part in the study, however those that did not gave reasons such as they lacked the time and availability to take part.

Following discussions between the researchers (DM, MJ and NB) prior to the start of the study, a decision was made to aim to interview ten participants. As suggested by Baker and Edwards (2012) this decision was based on several factors such as examining previous research in the area with numbers then adapted based on the recognition of time available to the research project, availability of potential participants, and what fitted with the chosen methodology. It was also predicted that ten interviews would be able to provide a sufficient level of data to understand IMH nurses perceptions of working on an IMH ward under special measures. This was done with the understanding that if themes had not developed from the data available and data sufficiency had not been reached as deemed by the researchers (DM, MJ and NB) involved in the project, further interviews could be conducted if required.

The majority of potential participants approached took part in the study, however those that did not gave reasons such as they lacked the time to take part or were unavailable till after the end of the studies recruitment period. In total, ten participants were recruited who all fitted the inclusion criteria as they were qualified IMH nurses who had experience of working on an adult IMH ward that was under special measures. Of the individuals who elected to take part, three were male and seven were female. Limited information on the demographics of participants is included in the study to ensure anonymity of those taking part.

Procedure.

Following ethical approval potential eligible participants were approached with an information sheet (Appendix D) and consent form (Appendix E) whilst on the inpatient ward working. Following initial discussions with lead researcher (DM) and taking of consent, a time and place for the semi-structured interviews with lead researcher (DM) was arranged with the participants that suited their working schedule with interviews held in quiet rooms both on and off the wards.

Data was collected via semi-structured qualitative interviews completed with lead researcher (DM) which were recorded via Dictaphone with individual IMH nurses. Semi-structured interviews were chosen as a method to allow rich individual discussions following targeted questions regarding special measures (see Appendix F).

A semi-structured interview schedule (see Appendix F) was shown to participants before interviews were conducted to show the form of open questions and topic areas that would be covered, but space was left for individual interviews to provide additional data dependent on their own individual experiences.

Following discussions between researchers (DM, MJ and NB) after ten interviews had been completed and data analysed with themes produced, it was deemed that there had been a sufficient level of data to evidence the themes found from the interview data collected in relation to how participants perspectives on special measures has impacted on their experience of working as IMH nurses on an adult inpatient ward under special measures. Issues surrounding data sufficiency are discussed in the limitations section of this paper.

The average length of the ten interviews conducted was 39 minutes which was deemed during consultation between researchers (DM, MJ and NR) sufficient length to cover questions in the interview schedule, with all recorded via Dictaphone which were then later transcribed for coding by lead researcher (DM) (see Appendix G for an example coded transcript).

Analysis.

This study consequently chose to complete an analysis which took an inductive approach to search for semantic themes to understand participants' experiences. An inductive analysis was chosen as it fits with the contextualistic critical realist epistemology informed by critical realism (i.e. Willig 1999) and allows the semantic themes generated to be closely linked to the data as provided by participants (Braun & Clarke, 2006). The analysis was informed by the principles of inductive TA which involved the coding of sections of qualitative data which are then collated to recognise themes which are developed from the coded data (Braun & Clarke, 2006). As proposed by Braun and Clarke (2006), TA was conducted by the primary researcher in six phases. The first involved becoming familiar with the data by initially transcribing the recorded interviews and then repeatedly reading the typed transcripts. The second phase took the form of making initial codes where participants referred to their experiences in relation to special measures on the transcripts (See Appendix

G) with the third phase beginning once all the transcripts had been coded and codes collated. This involved examining the collated codes to search for semantic themes and sub themes. Phase four involved reviewing of the themes and refining them, with phase five being the process of naming the themes, with both phases completed in collaboration between researchers but led by lead researcher (DM). This included a description of the themes and how they fit into the overall narrative of the study, with the final phase involving the writing of the report.

To ensure the analysis was completed appropriately, Braun and Clarke's (2006) 15-point checklist for good TA was consulted (Appendix H). Following this, it was deemed to meet the criteria of project completion.

To check validity and reliability of codes and emerging themes, constant comparison was employed as well as both additional researchers (MJ and NR) were provided with coded transcripts and collated codes with suggested candidate themes. These documents were then discussed with both to clarify and review themes to ensure that themes represented the collated data and transcripts appropriately. This involved assessing code terms used, examining suggested examples of data associated with codes to identify matches, and emergent themes associated with a collection of codes including checking naming of themes. Once themes had been collectively ratified between researchers with the lead researcher (DM) having final say on included themes, extracts from the original transcripts were selected to illustrate the themes effectively, which itself helped identify an overall narrative of the study. This process of collaboration helped to provide a level of inter-rater reliability to the final themes and narrative.

Ethics.

Ethical approval was granted by Bangor University School of Psychology, and the Health and Care Wales Research Ethics Committee and Betsi Cadwaladr University Health Board (BCUHB) Research and Development Committee (Appendix A; Appendix B; Appendix C). As shown in the information sheet (Appendix D), ethical consideration was given to several areas including, but not limited to; ensuring informed consent, explanation of procedure, confidentiality of participant data, issues around disclosure, explanation of freedom to withdraw, and information of whom to contact if there are difficulties encountered during the project. Information was also provided around how General Data Protection Regulation applied to participants data, as well as information for local support information if required due to distress following interviews.

Researcher reflexivity statement.

As part of the qualitative TA methodology, it is suggested that it is important for the researcher to recognise their own personal position in order to understand how their perception can impact on the final analysis (Creswell & Miller, 2000). As such, the researcher kept a journal to identify issues raised as the research progressed from initial idea to finished paper. The journal helped identify that the researcher's family background of growing up in a household with both parents working for the NHS, one of which was a mental health nurse who later became a senior manager, led to an interest in working with this organisation and staff group. This gave the researcher an opportunity to hear about what it was like working as front line staff, but also of hearing about quality improvement measures being implemented to ensure that patient care was being upheld and the NHS continued to strive to improve its services. This gave the researcher an understanding of the duality of the benefits of quality improvement but the difficulties bringing about cultural change to improve patient care. The journal also helped recognise one of the researcher's key interests in the topic arose from working alongside staff such as mental health nurses who

were working under special measures and how this impacted on their ability to deliver high quality patient care. This experience established a belief that a missing voice from the debate around special measures were front line workers leading to the current project.

Results

Themes.

The analysis provided one main theme permeating four key themes, with related sub themes derived from the data as shown mapped in Figure 1.

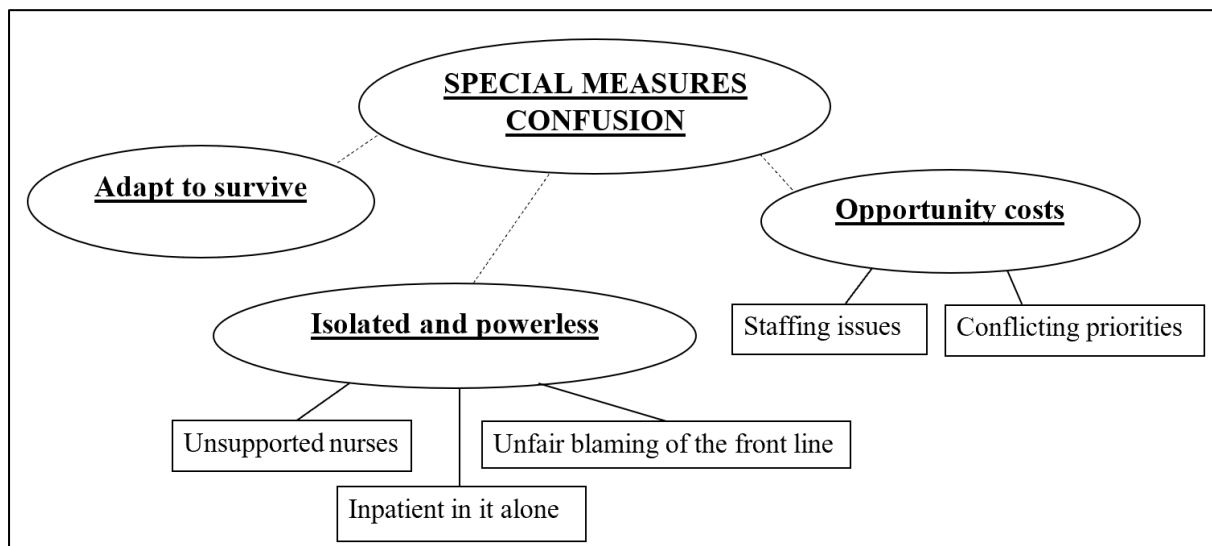


Figure 1. TA Theme Map

Special measures confusion.

This main theme identified the confusion surrounding special measures, its definition, its impact and its process. It permeated the other key themes and impacted the way IMH nurses perceived their experience, and the difficulty they had determining special measures impact from general IMH working. **P2** – *'it's hard to tell what was directly affected by special measures, or how it would be different if we hadn't been in it, would it have been different? I don't know, but I would say there have been noticeable changes since when special measures came in'*.

Elements of this theme also played out in specific special measures confusion. IMH nurses felt the information around SM had not been explained, was minimal and they had to find it themselves. They felt it was hard to access and was something they would have to go look at in their own time. **P7** – *‘like I say its words that is just handed down, the trust is in special measures, but when you are on the front line, unless you are taking time to read those articles, or to read what is really going on, it becomes the environment that you are working with, the restraints that you have got, the situation that you are in. And from that that is just what you have to work with on a daily basis.’*

There was confusion over why the health board had entered special measures and what the benefits of the process had been and what they would be once out of special measures. There was also confusion over what was specifically special measures related and what was not, and whether what staff were doing was having a direct impact on that. **P2** - *‘I don’t know the exact details of why we are in special measures, I have never had it explained to me in quite simple terms as to this is what it means ... never sort have had anyone say to me because we are in special measures this is going to happen, or this isn’t going to happen until then, ... Are things improving, who is regulating that and deciding when, it’s not something that you are really kept up to speed with.’*

A variety of suggestions were given to explain special measures, with most individuals feeling that making financial savings was a key part of getting out of special measures and feeling this was the part they felt most clearly impacted on them day to day. However, others felt a major cause for the health board being in special measures was due to accusations and investigations into poor patient care. It was felt there was a mixture of other national financial factors which made it hard to determine exactly what was caused by special measures and what wasn’t. **P10** – *‘We are in special measures is because of our financial position and obviously other healthcare incident elements, but the main impact for us is the*

financial reason we have been under special measures, but obviously that can be mixed in with other financial cuts across the UK’.

Overall, this theme of ‘Special measures confusion’ impacted heavily on the subsequent themes in this analysis, with a key element being this studies attempt to draw the specifics of the impact of special measures from general IMH working, the difficulties of which are discussed later in this paper.

Isolated and powerless

This key theme identified the feelings of isolation and powerlessness to change anything under special measures and included three sub themes, ‘unsupported nurses’, ‘inpatient in it alone’ and ‘unfair blaming of the front line’.

Unsupported nurses.

This sub-theme captured feeling high levels of legal and moral responsibility to maintain high levels of care for service users, but also responsibility to bring about improvement under special measures, all while not feeling supported to achieve what seems like an impossible task in a job that seems to be getting harder. **P9** stated *‘I think people in upper management get an idea of how things should be done in an ideal world under special measures..., but you need the people on the ground to actually spend time with people to actually do these things, and ... it’s not always possible, we are always firefighting, even more so under special measures’*

IMH nurses already felt they were **P2** - *‘treading water’*, but believed further pressure was filtered down to them in the forms of additional assessments under special measures from faceless management. IMH nurses felt the results showed lots of areas needing improvement, but nothing would be done. IMH nurses felt **P1** - *‘management say everything is going well’* but do not discuss this with IMH nurses on the ward. **P1** – *‘Under special*

measures, we are asked to do... more assessment and audits to tick boxes for senior management who we don't ever see, and we never know the outcomes ..., but things don't improve on the ground because of them, and you think, what was the point?'

IMH nurses felt the blame should be allocated to the senior executives in charge when special measures was implemented, but instead it was IMH nurses who were left dealing with the fallout of special measures in terms of dealing with service users with less resources and being blamed for inadequate care. They felt unsupported to achieve more with less, by those they believed were truly culpable for special measures occurring. **P9** – *'it seems unfair that it was the incompetence of the most senior management with finances that got us into this mess, but you hear of managers supporting each other, while we are left trying to do our day job under harder circumstances ... with only criticism when we don't achieve and no praise when we do.'*

IMH nurses felt senior management's focus while under special measures was to avoid litigation which could be blamed directly on the organisation such as avoiding SU's being **P.2** - *'trapped in rooms due to faulty doors'* which staff felt was **P.2** - *'understandable'*. However, nurses also felt that senior managers did not offer the same level of protection against litigation to nurses, such as not releasing funding for more staff even though IMH nurses felt they had **P.9** - *'dangerously low levels of staffing'*. This meant IMH nurses believed an error which could be blamed on IMH nurses and lead to them **P.9** - *'losing their pin'* was made more likely to occur as they could not maintain safe levels of observation on the ward. This fed into the feeling they were being left to be blamed rather than be supported by senior management and the organisation. **P6** – *'all we do is take away means to self-harm which could litigate the organisation, leaving service users with forms of self-harm that can be blamed on a nurse. That's where the stress is coming from now'*.

Inpatient in it alone.

This sub-theme captured IMH nurses feeling of being separate from community mental health and physical health services, and that they were the last location for the most distressed individuals and expected to help them recover.

IMH nurses recognised the whole health board were also in special measures and thus affected by financial pressures. They felt this limited other parts of the mental health service capacity to deliver, which meant the most distressed individuals ended up in inpatient where IMH nurses had to help but were wary of the disconnect between availability of services upon leaving the ward thus feeling they were setting the service user up to fail. **P3** - *'We need to take it down to the nitty gritty, this is an acute ward, this patient is in here because things in the community aren't working, there is no other alternative. ... And you know whilst it is great now they have got psychologists on the ward, because of various financial difficulties to do with special measures, they have still got to wait years to be seen out in the community. ... Its bollocks really isn't it.'*

IMH nurses felt there was no third sector support and a lack of cohesion between community services (including specialist support services) and inpatient services. This not only added to IMH nurses sense of increased levels of pressure to help, but also affected distressed service users who felt disconnected from support in the community. **P3** - *'I think that we are very isolated anyway, that we don't have much involvement with community services or third sector services. Community ... are under a lot of financial pressure since special measures so it's like great, he is another one I don't have to go and see...but for the patient they do feel that they have been dumped here ... We are their family and support whilst they are here ... it's like a bubble, we are like a bubble.'*

IMH nurses believed the stigma of mental health means there is a poor understanding from society **P2** - *'the general public doesn't know how limited we are working in inpatient mental health...that there is no quick fix'*. This includes physical health services as well, who also do not recognise MH service's limitations. **P3** - *'Physical health nurses are under their own pressures because they are in special measures too, but I think when we go over there because of self-harm, there is a culture of "bloody mental health" you know and we are an additional pain in the arse because we shouldn't have let them hurt themselves ... but it's a lack of understanding on their part of our limitations in what we can realistically do to stop people sometimes'*.

IMH nurses also felt looked down on by other teams within mental health such as community mental health teams who should understand the difficulties of special measures and how it impacted on working with the same client groups. **P6** - *'I feel very strongly that we are the elite, but we are poor at asserting that. And a lot of the people in the community are in the community because they recognise that they would struggle to cope long term in this environment, because people don't want to admit their own frailties, so their coping mechanisms is to look down on us a little bit.'*

IMH nurses felt responsible to help carers and service users but felt carers and service users expected services to take care of everything and absolve them of responsibility. IMH nurses felt special measures limited this, but also it was impossible to meet the expectations of carers and SU. **P5** - *'carers and service users have different expectations of what the service can provide at times, ... that we should do everything for them, and sometimes we are not able to ..., even though we try to meet those expectations, ... and at its been a lot harder since being in special measures to meet those.'* When IMH nurses failed to deliver, service users would tell them. **P1** - *'I don't think they are appreciative of the work, or the financial pressures we work under because of special measures, and I wouldn't expect them to, but... I*

know for a fact that the ward gets slated by inpatients on social media, day in day out, even though we are trying our best'

Unfair blaming of the front line.

This sub-theme captured IMH nurses feeling that they were left to deal with and take the main fall out of special measures as they were the service users facing staff, dealing with individuals in the most distress. They felt they were unfairly blamed by being in this position.

P1 – *'It just seems special measures has magnified that speed to blame the practitioner, and we try our best to keep everyone safe, but society and sometimes senior management doesn't recognise we are the last line of defence being inpatient staff ... you're left feeling burnout carrying that.'*

IMH nurses felt they were being treated differently since special measures as saving money was of paramount importance. This included a reduction for only IMH staff in being paid overtime causing them to lose out financially. **P5** – *'they won't pay overtime anymore you only get a bank shift, but they class it as a second job, so you get taxed and national insurance and pension on it again'*. Though this measure did not seem to be applied across the health board with physical health nurses still getting overtime, leaving IMH nurses feeling unfairly treated. **P8** – *'They have stopped overtime, but just here, the main hospital they still get paid overtime'*. Staff reported the change since special measures meant even basics were being held back in the name of saving money causing IMH nurses to feel frustration at being unable to get on with their job. **P8** – *'the pens are like rationed... They have now locked the stationery cupboard. ... I had to go and speak to someone on a different ward ...But then you are wasting time then, looking for things because you can't get them from the cupboard because it is locked!'*

IMH nurses also felt that it was not just them being unfairly treated by special measures, but also those they work with such as student mental health nurses on placement who missed out by proxy on learning experiences because of the extra demands placed on them by special measures. **P1** – *‘this goes back to working in special measures, I reckon a lot of students have terrible experiences because of the pressures on nurses to be nurses let alone to teach a student.’*

Alongside the aforementioned feeling that there was a reduction in protection from litigation, IMH nurses felt besieged as they also experienced a constant barrage of negative media directed at them when they felt they were burning themselves out trying their best for SU. **P4** – *‘The media is all very negative about the health board being in special measures... its awful really because you feel like you try your best, you’ll go without your breaks, you’ll forfeit everything and even you know going to toilet, sometimes you think I just haven’t got time. You put everything into your work, you go home, and you are just absolutely knackered, you can’t do anything and then you turn on the tv and all it is reports of staff, how bad they are, and you think that’s not true.’*

Opportunity costs.

This key theme identified the difficulties surrounding the opportunity costs of what IMH nurses and the service as a whole missed out on because of IMH nurses having to make decisions using their limited time. This was heavily affected by staffing mix and levels on wards which they felt had been impacted by special measures. This included two sub themes ‘Staffing issues’, and ‘Conflicting priorities’.

Staffing issues.

This sub-theme captured the difficulties around staff mix and utilising bank staff, but also staffing levels with individuals leaving inpatient work for better opportunities, but also for stress.

IMH nurses spoke about when special measures originally came in, how the additional pressure and worry caused experienced staff members to leave for other jobs and general numbers to decrease, furthering adding to the difficulties of the job. **P1** – *‘since when special measures came in, there’s been a dramatic change in staff numbers I’d say. staff have gone, you know long standing members of the team... they’ve gone... with stress I think and stuff like that and onto pastures new’.*

IMH nurses also stated they felt a lack of security in their careers as there was a change in the types of roles available, due to the inability to secure long term funding it seemed only short-term secondment opportunities arose. **P2** – *‘what I have noticed under special measures, ... when people leave they are filling with temporary secondments, ... it’s just that feeling of job security isn’t the same ... it can be quite frustrating ... you get burnt out quite quickly’*

Special measures seemed to lead to recruitment problems which increased the pressure IMH nurses felt. This was put down by IMH nurses to the lack of finances for staff, but also negativity surrounding the meaning of special measures and vacancies not being filled. **P7** – *‘The restraints that seemed to have come around from special measures seem to contribute to the shortage of nurses generally anyway, and how a health board in special measures is perceived has made recruiting very difficult, which has made pressures on the ward even more difficult to us on a daily basis’*

IMH nurses believed that due to the financial pressures of special measures, there were fewer IMH nurses permanently employed, there was less appetite to fill the vacancy

gaps with experienced agency nurses, and more use of cheaper inexperienced bank staff. Some bank staff lacked mental health training and experience which meant IMH nurses spent more of their work time directing and explaining the job roles to bank staff, rather than just being able to get on with their nursing duties. This increased IMH nurses sense of frustration with the process. **P1** - *'that goes back to the point of its quality not quantity aspect. Under special measures, there is more use of bank staff ... I have nothing against bank staff ... but it's not great is it, having some guy who normally works on a stroke ward come in and doing a shift not having a clue anything to do with risk, anything to do with mental health acts, you know you are spending half your day telling them what to do. And it's like thank you for coming in but what use are you?'*

Conflicting priorities.

This sub theme encapsulated the difficulties allocating time to the demands of SU, carers, other staff and management under special measures.

It was suggested there were confusing statements of what a priority is to senior management under special measures as staff were expected to do their normal job on top of the additional pressures of special measures. **P3** – *'we already feel under a lot of pressure because of special measures, so when we are told we need to be doing more, especially things which aren't possible, by management who don't understand because when was the last time they worked on the wards? They wouldn't bloody survive on these days, twelve and a half hour shifts, sometimes no break whatsoever if you are short staffed'.*

At different times it could be audits and paperwork, or other miscellaneous tasks, which got in the way of delivering care to service users which is what IMH nurses felt was the priority. **P9** – *'you could turn up ... and be told you need to check maintenance but there was no recognition that I may be the only qualified on the ward, people are in distress, ...*

and then they are expecting you to go around and do a maintenance job ... you are left thinking, if I don't check what they suggest, am I going to get in trouble for that? but there is someone in distress, that should be a priority ... what do they want us to do?'

IMH nurses felt special measures hindered the amount of time to implement training of new techniques, psychological methods, or adapt work to be applied in group formats which meant service users missed out. **P4** – *'there is lots of courses, we are all quite keen on going on ... especially the psychological ..., we need to be doing these things with people, but we just haven't got the time due to other priorities being under special measures.'*

Adapt to survive.

This key stand-alone theme identified how staff intimated they had to adapt to the special measures process and its impact.

IMH nurses felt the pressure of being under special measures brought the team closer together through teamwork and communication, but also made them work more creatively.

P1 - *I reckon people have benefited. I don't think you realise you benefit... it's like made you adapt to different situations quickly. It makes you closer with your team as well. ... we are generally positive, like I stay positive because it is like it is what it is you know, and we have got to find ways to work around it.'*

IMH nurses felt it took a particular character to be able to work on an IMH ward, and a sense of humour (sometimes dark) to manage. **P5** – *'It sounds bad but there is awful lot of kind of black humour and we try and not to take it all so seriously. Obviously being very professional and stuff with the patients, but with the staff ... there is definitely a dark sense of humour ...we try and say just try and laugh, but you have to laugh sometimes because it is so bad.'*

They characterised a good ward manager as an individual who helps protect the IMH nurses from pressure but also gets involved, who offers a lack of strict hierarchy which helps aid teamwork and everyone ‘mucking in’. **P7** – *‘A good ward manager, and sometimes I think it’s the personality group you have got everyone wanting to do the same job, everyone wanting to go in the same direction, ... able to work together and support each other.... Our ward manager is excellent, and gets very much involved in patient care, will help the staff.’*

Discussion

As previously suggested, though there have been qualitative explorations of staff working in a number of healthcare settings including IMH, there is a lack of qualitative studies exploring staff experiences of working under special measures. This study aimed to provide insight into how adult IMH nurses perceive special measures to have impacted on their experience of working in an organisation under special measures.

Themes.

The analysis of participant data produced a singular main theme of ‘Special measures confusion’, which permeated the three key themes with related sub themes: ‘Isolated and powerless’, ‘Opportunity costs’, and ‘Adapt to survive’. Special measures confusion encompassed the confusion of what was expected of staff under special measures, and the expected impact of their work. Isolated and powerless captured the feelings of nurses having to manage alone under the circumstances of special measures, unsupported by management, and penalised rather than rewarded for their efforts. Opportunity costs captured the difficulty of managing conflicting priorities with low staff levels and problematic staff mixes. Adapt to survive involved nurses’ ability to work creatively to overcome the additional barriers of working under special measures. The emergent themes are discussed in more detail below.

Special measures confusion.

The singular main theme of ‘Special measures confusion’ which permeated the analytic narrative of the data was exemplified by the confusion of individuals who were working in IMH services in understanding special measures, what their expectations of special measures were, but also how special measures were felt to impact IMH services differently in comparison to the impact of standard IMH working practices. This theme of special measures confusion recognised the importance of information and understanding,

with IMH nurses feeling they did not have enough information on what was a large organisational change that was clearly affecting their working lives. Research by Kelliher and Parry (2015) surrounding organisational change suggests major transformation within an organisation can bring ambiguity and additional stress to staff experiencing it. The implications of this are that detailed information and managerial support surrounding the fear of the unknown with regards to special measures could alleviate anxieties for staff going through this process (Carleton, 2016).

Isolated and powerless.

The theme of ‘Isolated and powerless’ was emphasised by IMH nurses reporting experiencing feelings of being isolated and powerless, of feeling unable to change anything, but having to work alone to manage which they believed created additional pressure on them. IMH nurses felt legally and morally responsible for their service users care under special measures, yet they did not feel supported by management to provide the high-quality care they wanted to deliver. A systematic review by Huffman and Rittenmeyer (2012) found nurses striving to implement optimum care in a chaotic environment suffered with moral distress, a sentiment echoed by the distress IMH nurses felt in this research. IMH nurses believed that inpatient staff were isolated more under special measure from the community, and left holding the riskiest clients, something that other healthcare teams did not always seem to understand or appreciate. Delaney and Johnson (2014) found inpatient psychiatric staff struggled to articulate the importance of their role to others regarding patient safety, thus the inpatient speciality was sometimes misunderstood. This breakdown in the understanding of the inpatient role could have added to staff’s pressures and thus explained their feeling of isolation. Fotaki and Hyde (2015) proposed that organisational blind spots allowed failures of unsuccessful courses of action chosen by decision makers to be blamed on operational members such as front-line staff, especially those with legal responsibility for service users

care. This explanation links with how the IMH nurses interviewed felt they were trying their best working with service users on the front line while trying to manage the additional pressures of being under special measures, however instead of being rewarded, they felt unfairly treated.

Opportunity costs.

The theme of ‘Opportunity costs’ was shown through IMH nurses reporting feeling high levels of pressure regarding the difficulty with what to prioritise due to having so many additional demands placed on their time whilst being under special measures, with staffing levels impacting on this dramatically. IMH nurses found additional unqualified staff sometimes created more barriers to effective working in IMH wards rather than helping lighten the workload of qualified staff on the ward. IMH nurses suggested this increased workload led to IMH nurses stress levels increasing, which in turn contributed to IMH nurses leaving the job due to burnout. Van Bogaert, Clarke, Willems and Mondelaers (2013) found where there was negative ratings of management and organisational support, there was also poor job satisfaction, high intentions to leave, and low quality of care, with higher levels of burnout. This research also explains why the lack of perceived clarity from management dictates to front line staff, as well as trying to manage high expectations from other stakeholders, about what was a priority added to their negative experiences.

Adapt to survive.

The theme of ‘Adapt to survive’ was shown through IMH nurses reporting they had learned to adapt to the pressures they experienced when change had come in the form of special measures which was initially difficult, but it allowed them to work around barriers as a team using creative thinking. This was evidenced by Glaser et al. (2015) who found the ability to have new challenges, such as the ones that come with being under special measures, and to adapt to these using problem-solving and new learning are crucial for motivation and

creative performance in work. However, they also observed as the scale of the demands of the challenges increased, so did the stress levels of the job recognising the limitations of staff being placed in stressful positions.

Reflections on process.

Participants appreciated the opportunity to discuss and reflect on their experiences, however participants sometimes struggled to stay focused on the impact of special measures due to focus on their day to day work and having an opportunity to discuss this.

Staff showed through the theme ‘isolated and powerless’ they felt unsupported by management and other teams, and showed through the theme ‘opportunity costs’ they felt understaffed and under resourced. Staff in this study attributed these factors to being under special measures implementation, but these themes show feelings which are not dissimilar to the feelings of inpatient mental health nurses found in multiple studies across the globe where staff are not going through special measures (Cleary et al., 2012; Currid, 2009; Hamdan-Mansour et al., 2011; Sherring & Knight, 2009; Ward, 2011). Other difficulties staff stated they experienced within this study linked with their current problematic organisational culture were also attributed to special measures being implemented. However very few staff interviewed fully understood the reasons why special measures had been implemented, how it was meant to be delivered, and the expected final result once special measures process goals had been achieved, something which permeated the analysis shown through the theme ‘special measures confusion’.

There was minimal understanding that a historical problematic organisational culture that had not been able to change over a long period of time despite many attempted interventions had negatively impacted on the quality of patient care, thus leading to the allocation of special measures with mental health services being a key area requiring

improvement. This lack of understanding shows the difficulty, and thus the confusion, of identifying whether problems that were currently occurring on the ward were to do with previous problematic organisational cultural issues which had yet to be remedied, current organisational issues, current social issues (e.g. national government funding levels etc.), problems with the implementation of special measures, a combination of these factors, or none of these factors, as the answer is essentially unknown.

The aim of this study was not to provide a definitive answer to this, but to highlight what staff's perceptions were of special measures, and how it impacted their experience of working in a service which was under special measures. However, the fact staff attributed these difficulties and their distress to special measures, rightly or wrongly, suggests that helping staff to better comprehend what special measures is and its process could be useful for staff's understanding. Research by Kalleberg, Nesheim and Olsen (2009) suggests that involving and consulting staff on organisational change can reduce stress levels. Involving staff could educate them in these areas which could help ensure that staff's attributions to where their difficulties lay were directed towards the appropriate target, whether this was to do with special measures or other areas. This understanding and involvement could also potentially help to speed up the implementation of improvements and alleviate staff's distress levels which could result in improved patient care (Kalleberg, Nesheim & Olsen, 2009).

Other reflections include recognising participants were split across different geographical areas, so it was interesting to see the different perspectives but the parallels between experiences, which ultimately made the analysis of the wider experience easier due to similar narratives. The authors' use of meeting with supervisors and keeping a recorded journal of their experiences was useful in attempting to put aside the authors own assumptions when interviewing staff and analysing the data, however it must be recognised that it was impossible to completely remove sympathies the author had towards fellow NHS

staff members working in difficult conditions. This provided a more balanced analysis more in line with the perceptions of working under special measures from the viewpoint of IMH nurses, but also allowed the author to recognise areas of their own potential influences when presenting this.

Limitations.

A potential limitation was the size of the study with only ten participants taking part from one particular region of the UK. This was deemed an acceptable number of participants following discussions surrounding predicted sample size required to identify perspectives on special measures and how it impacts on working in an adult mental health inpatient service which is under special measures (Baker & Edwards, 2012). , However, a larger and more diverse sample from multiple areas would have offered a more varied data set which could have provided a different thematic narrative. Likewise, a different qualitative analysis methodology may have also produced different findings. TA as a methodology for the analysis was completed to a level which allowed themes to emerge from the data providing an overall understanding. However whether true data sufficiency was reached in terms of understanding the experience of all IMH nurses working under special measures could be contested. A larger sample of nurses would have nullified this potential limitation as to ensure true data sufficiency was reached, however this must be balanced with wasting participants times if their data was deemed redundant if no new themes were emerging. Individuals taking part were all IMH nurses working in adult mental health, meaning only a selected number of one of many potential professions experiencing special measures were asked their views. A key factor in understanding the results was the researcher's own subjectivity surrounding their experiences and appreciation of the nurses' perspective while conducting semi-structured interviews and analysing the data produced from these. As previously stated in the 'Author's reflective statement', the researcher had their own biases

and sympathies which are acknowledged, and it is understood that these subjective elements will have influenced the final results. As such, these results should be viewed with the understanding of the lens of the researcher's subjective experience. The validity of the analysis drawing out themes specific to special measures has been raised in the analysis, and as such, bring into question how whether these themes would emerge if the wider population of staff working under special measures were also interviewed.

Future directions.

The focus of special measures as a method for managing organisations in difficulty is well established, however the lack of understanding of what individuals working on the front line of these services is little understood. This study provides an understanding of what individual working under this process experience via the themes from the interview data. The themes developed within this study show what staff struggle with and benefit from, thus allowing them to manage within the system.

The implications of these findings locally could lead to discussions between all levels and teams of the local health board hierarchy around how to manage the confusion reported by nurses around their perception of special measures. Likewise, these discussions could help alleviate the isolation that nurses reported feeling, clarify the priorities of the health board whilst under special measures and help spread information surrounding what adaptations nurses reported saying were helpful. On a more national level, the finding could help facilitate a national discussion about what other areas of the country perceive special measures to be and what they perceive to be the impact of this process on their work. Nationally, this could have an impact on how this process is managed in other organisations utilising these insights, such as providing clear information for staff about special measures, so that people can understand it and have less trepidation about working under it.

Potential future directions in terms of research could examine more nurses to see whether the themes identified within this study are held more widely, or even expanded out to nurses in other Health boards or Trusts who are experiencing special measures. A main theme throughout the analysis was the separating out the impact of special measures from the impact of standard IMH working practices. There is a potential that the themes here are more about general IMH working than about working under special measures and as such, research clarifying this would aid the theoretical narrative. There is also scope to complete ethnographic action research to understand individuals' experiences as special measures is implemented. Likewise, other professions were not asked and therefore this could be an interesting avenue to explore the view of other staff members who work both within and outside the area of mental health. Senior managers did not take part in this study, but their narrative of working under special measures could provide a different view. The experience of being treated under special measures could be examined to explore service users experiences of special measures and whether they feel this has impacted on their care positively or negatively. The aim of any organisation in special measures is to eventually no longer require the label or process, as such, to examine nurses' thoughts once they are out of special measures and whether their experience is any different could offer an insight into what special measures had both a long-term and short-term impact on. On a similar theme, interviewing IMH nurses who have not experienced special measures to determine their experiences of working in inpatient services may offer a contrast to the themes highlighted in this paper.

Conclusion.

This study has offered an exploration of mental health nurses experiences of working under special measures. It is known that special measures is seen as being a process based on politics and management theory rather than an understanding of systems and how people

work. It is also known that IMH nurses have a key role in helping an organisations come out of special measures, however recognition of that role with a greater understanding of the limitations of the special measures process must be established to reduce pressure on IMH nurses. It is hoped that this research provides a basis with which to understand special measures within the NHS from the viewpoint of IMH nurses who work on the front line of services, and therefore provide a discussion and an understanding surrounding the cost-benefit analysis of the process for all levels of an organisation in special measures.

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Section 4: Contributions to Theory and Clinical Practice

This section examines the previous papers and explores how their findings contribute to current theory and clinical practice. Both theoretical and clinical implications are discussed after an initial overview of the literature review paper and the empirical paper.

Overview of papers

Literature review.

Previous literature reviews on interventions for occupational stress and burnout in healthcare staff have included some UK based studies but have tended to have a more global focus including countries such as Australia, America, and Canada. Due to the inclusion and exclusion criteria for the interventions reviewed in these studies, several UK based studies had not been covered. Also, the different cultures between these countries healthcare systems highlighted scope for more research which focused specifically on the NHS in the UK due to its particular constraints both culturally and financially in being a government funded organisation.

This literature review aimed to explore the different types of interventions used to reduce burnout and occupational stress on staff within the NHS. For the purposes of the literature review, the studies interventions were categorised under three overarching themes of intervention which included ‘individual support’ interventions, ‘training staff in therapy skills’ interventions, and ‘organisational and team-based’ interventions. The results suggest that, in line with previous research, there are several methods of doing this, with some studies showing significant results though not all in reducing occupational stress or burnout. However, none seemed to show reliable, consistent, effective methods of reducing occupational stress or burnout in NHS staff.

Empirical paper.

Current governmental methods for managing public funded organisations that are deemed to be providing an inadequate service, even after multiple interventions to improve quality of services, include placing those organisations into a process of major organisational change called ‘special measures’ to enforce improvement. Though reports are produced at an executive level assessing the impact of special measures on improvements in care or finances, at the time of writing, there have been no published empirical papers examining front-line staff’s perceptions of what special measures is and how it impacts their working practices. This is even with staff being the individuals who deal with both delivering the special measures related changes to service and manage service users care on a daily basis. Inpatient mental health nurses were selected for this study as they are a key staff group which have been shown in the literature to already be dealing with difficult working environments managing highly distressed individuals (Halter, 2017).

The aim of this qualitative study was to examine adult IMH nurses’ perspectives on how special measures has impacted on their experience of working in the organisation. This was done through conducting semi-structured interviews with ten IMH nurses who had experience of working on an adult inpatient mental health ward which was under special measures. The interviews were analysed utilising Thematic Analysis and produced one main theme (‘special measures confusion’) which permeated the three key themes (‘isolated and powerless’, ‘opportunity costs’, and ‘adapt to survive’) with related sub-themes. The themes showed the difficulties staff experienced working on an inpatient ward under special measures and the complexities of managing the barriers that special measures presented to them alongside other ward-based difficulties.

Methodological limitations and future research

As previously stated, in the NHS, as with many large organisations, constant culture change is required but can be difficult (Allcock et al., 2015). A key method of understanding whether change has occurred over time is through longitudinal research which was lacking across both papers. The empirical paper had no longitudinal evidence to draw on with regards to special measures in the NHS, with the only papers published about special measures in the education sector examining the effect on school staff. A major criticism of the papers within the literature review was the lack of follow-up in interventions for burnout. Though not feasible for the current empirical paper, a follow-up study examining the effects once out of special measures could have provide an overall better understanding of the changes in staff's perceptions of special measures and how this impacted on their working lives. Caruana et al. (2015) suggest longitudinal studies can offer many advantages which could benefit the research base such as by following particular individuals within a cohort over a timeline, and the ability to identify and relate events to specifically introduced variables over a period of time. Therefore, more longitudinal research could have benefitted both areas by providing a better and richer understanding of what a participants' true experience was of both interventions and their perceptions of special measures respectively.

Although the sample size for the empirical paper was deemed adequate, it could be argued that small sample sizes could be seen as an issue in both the literature review paper and the empirical study. Healthcare staff can be difficult to access as a participant population for research (Hewison & Haines, 2006), which was felt across the literature review studies and was a factor in deciding the number of individuals to recruit for the empirical paper's study. In qualitative analysis, a small sample is deemed acceptable based on rich data sets. However, the views of many nurses were not collected, and in respects to all organisations within the NHS which are also under special measures, the numbers of participants asked about special measures was minute. Similarly the literature review's sample sizes in

comparison to the larger population of the NHS workforce were also small (NHS Digital, 2018). The small sample sizes could have meant that the impact of interventions were underestimate or overestimated, while the perspectives of special measures may have been specific to the participants who took part exclusively. Both these elements could limit the scope of both papers narrative. Further studies using larger sample sizes would benefit the research area in providing an additional layer to the overall narrative from a larger and different population.

The majority of participants in the literature review were healthcare workers while the empirical paper examined IMH nurses. The fact only a small number of professional staff groups were covered across both papers meant several staff groups (professional, non-professional and non-healthcare staff) were not represented that would also be experiencing working under special measures, and also experiencing occupational stress and burnout, who therefore could have benefited from interventions (NHS Digital, 2018). The lack of record of the impacts on other staff groups in both papers limits the extent the narratives of both papers could cover. For contrast, an understanding of special measures from the perspectives of service users could also help shape the understanding for those on the receiving end of care under special measures and whether there is an impact, or whether care is improved from staff following an intervention to improve staff stress levels.

There have been many studies and reviews on both inpatient mental health nurses and on burnout (Gilbody et al., 2006; Richards et al., 2006; Westermann et al., 2014), yet as the literature review showed, there has only been a limited number of published studies which have examined interventions, and even fewer with significantly effective results in interventions for healthcare staff. There are also currently no published studies into how special measures is perceived, therefore its impact in terms of burnout is unknown quantitatively, let alone what intervention could help individuals manage individuals

perceptions of the special measures process. There have been attempts to collate methods for managing wellbeing in staff within the NHS from grey literature, but the suggested interventions are deficient in academic rigour which make it difficult to recognise whether they could be effective on a larger scale (Whitmore et al., 2018). More research into both papers areas of focus would build the research base specific to NHS staff to allow a better understanding in what could be effective in burnout interventions in general, but also for those working under special measures.

The literature review was a narrative synthesis while the empirical paper utilised thematic analysis. Although author subjectivity is a strength of both papers in drawing conclusions, the ability to bracket this subjectivity also creates difficulties in the validity of the analysis (Tufford & Newman, 2012). The use of different types of research methodology could have provided an alternative manner in which to interpret and produce data offering a different viewpoint into both papers research areas. For the empirical paper, thematic analysis is a well-established methodology (Braun & Clarke, 2006), however if an alternate qualitative research methodology had been used it may have produced different conclusions which could have contributed to the evidence base in a different way (Creswell & Poth, 2017).

It has been proposed that when assessing a new intervention, the cost effectiveness should be assessed (including economic cost, its effectiveness in terms of increasing utilisation of ‘good practice’, and the costs and benefits of ‘good practice’ relative to an appropriate comparator), and not just whether the intervention is significantly effective at reducing a singular targeted measure (Sculpher, 2000). The NHS has a finite amount of resources with an ever increasing range of areas requiring funding, as such providing an economic evaluation can help inform key decision makers on which interventions can be cost effective to fund to ultimately improve patient care while not wasting public money (Luyten, Naci & Knapp, 2016). Glasziou et al. (2012) suggest that financial arguments are powerful in

bringing about change in the NHS. Both papers examined the impact on staff's experience from interventions and organisational change, however neither provided an economic analysis of the impact of either the interventions examined or special measures' effect on staff. The cost of funding research in the NHS can be a major barrier to conducting studies such as those into interventions for occupational stress and burnout. Both the literature review and the empirical paper showed that there is a cost to staff if no intervention is provided, such as increased stress which can lead to more sick days (Jones-Berry, 2013) and can impact on staffs ability to provide high quality patient care (Farquharson et al., 2013). Interventions which are effective at dealing with staff stress are important to research, however effective interventions must also be economically viable if they are to be applied throughout the NHS's 1.5 million staff (NHS Digital, 2018). As such it is suggested that an economic evaluation is included as part of the analysis for future projects as this can help with making the case to commissioners or to government about making a change to services based on research conducted.

Contributions to theory

The empirical paper highlighted several areas where staff felt unsupported during the major organisational change that is special measures. They reported elements such as feeling unsupported, isolated, and spoke about confusion about the process. Several of these elements that were lacking are highlighted within the model of the impersonal process of compassion found within organisational compassion proposed by Dutton, Workman and Hardin (2014) (see Figure 1). Specifically, staffs' perceptions of how compassionate, or uncompassionate, the organisation is to them.

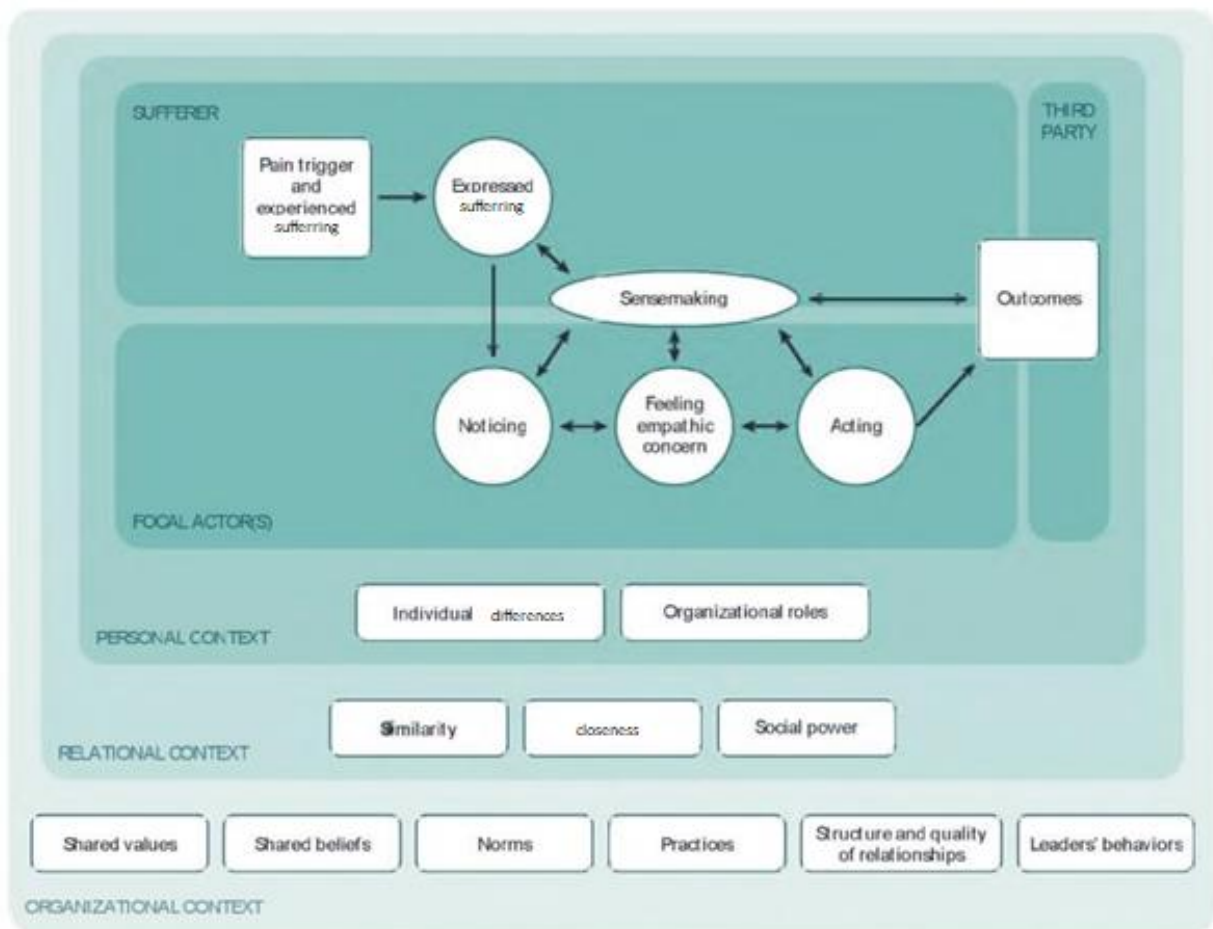


Figure 2. Organisational Compassion Model (Dutton, Workman and Hardin. 2014).

The model initially examines the individual who is experiencing suffering, and the importance in how they express this and how it is received. Within the empirical paper, staff spoke about their frustrations and anger to their ward team but did not express suffering directly to senior management. Goodrum (2008) suggests this avoidance of talking with superiors could be done in order to minimise looking weak. However in the NHS, although expression of suffering is not always stated explicitly to senior management, the high number of staff sickness absences through occupational stress and burn out provides the evidence that distress is there on a national scale (Jones-Berry, 2013). The model suggests this expression is key to begin to understand suffering and then apply compassion.

The model also examines how a focal actor needs to identify suffering, show empathic concern, act compassionately, and engage in sense making. The empirical paper

shows how ward staff's direct colleagues such as other nurses were the 'focal actor' as described in the model who empowered the distressed individual to manage under difficult circumstances. Ward managers also could be considered the focal actor at times, but senior management were not considered as acting in this role with regards to the participants in the empirical paper. The behaviour of ward staff acting as focal actors for one another was exemplified in the theme in the empirical paper around adapting practices to manage under special measures. This included staff stating they supported each other on the ward during difficult times, with ward managers considered helpful to staff as they provided them with compassionate support in the form of behaviours which are proposed by the organisational compassion model to be helpful. Atkins and Parker (2012) suggest that focal actors are more likely to offer this support if they view the sufferer as of good character, helpful and altruistic which staff believed they were as a working group. This resulted in stronger bonds amongst the staff team and ward manager. The component of the model which requires a focal actor helping make sense, and in this context it was staff, would mean the understanding they regularly came to was that their difficulties were caused by external factors they had little control over. For them, the major organisational change in the form of special measures which contributed to their negative experience was enacted due to the mistakes of senior executives with whom the staff groups had no contact. This caused a compassion-disconnect with those more senior staff, and a tightening of bonds between staff on the ward.

The model recognises context, with personal contexts impacting on both IMH nurses experiences and the interventions that could be used to improve that experience. The model proposes that ideal focal actors require high psychological flexibility, empathic personality traits, secure attachment styles, an understanding of the distress being experienced, and is more likely to come from a lower socioeconomic background (Atkins & Parker, 2012). Also, organisational factors such as high emotional load impairing focal actors compassion, or

organisational job role promoting minimal expression of emotions can harm a focal actors ability to respond. The empirical paper reinforced this as it showed the individual participants who were supportive were the lower paid ward staff who work in direct patient care roles within mental health and were more likely to embody the ideal elements to be a compassionate focal actor. Meanwhile, participant's perceptions of senior management were opposite of this and thus negative.

The relatability between focal actor and sufferer is key, with model examining this across the three areas of similarity, closeness and social power between the two roles. Supervision is a key area where these three elements can be enabled to have maximum effect, due to an increase in understanding promoting similarity and closeness, while minimising the power dynamic within supervision (Herbert & Caldwell, 2015). The literature review supported this theory as studies exploring interventions that utilised supervision support had positive feedback, although not always registered quantitatively.

The model's conceptualisation of organisational factors which promote compassion were shared values, shared beliefs, improved compassionate organisational practices, high quality structured relationships, and compassionate leadership behaviour. The empirical paper's themes all represented elements where participants felt a void in each of these areas, while most ineffectual interventions within the literature review either did not focus on these factors or did not include them. This model is a highly relevant as the absence of these compassionate aspects across both papers provide validity of the concepts suggested. The theme within the empirical paper identifying adaptive processes within the wards highlight the benefits where compassionate elements were used and as such implementation of interventions utilising elements of this model could play key role in improving working lives for staff.

Implementation of a compassionate model within public services.

There are key barriers as to why it would be difficult to implement the Organisational Compassion Model Dutton, (Workman & Hardin. 2014) in the NHS today. For example, the focus of NHS trusts on ensuring keeping within budget while trying to achieve patient care quality targets can mean the process of implementing a model which requires more time for communication between staff could be difficult. This could potentially mean staff are viewed as spending less time with patients which could be seen as violating the key role services are currently set up to do e.g. reduce waiting times and increase number of successful health interventions.

However, NHS organisations that have embraced a more compassion focused model have been shown to be more innovative, staff feel more valued, services have increased diversity, and staff feel more supported to provide high quality care (West et al., 2017). Therefore, the process of implementation of the Organisational Compassion Model in public services could be seen as a welcome addition to improve organisational working. This could ultimately benefit patients by providing a system for staff to be more compassionate to one another, and therefore be in a better position to provide high quality compassionate patient care. The three areas where implementation could occur is through training compassion to leadership, training teams to work compassionately and to engender compassion in individual workers.

Training compassion to leadership. Aspects of this are already being implemented through The Kings Fund paper ‘Caring to Change: How compassionate leadership can stimulate innovation in health care’ (West et al., 2017). The main aspects of this paper discuss the benefits to healthcare trusts of how compassionate leadership can help develop compassionate organisations that are able to innovate and improve quality of care for

patients. This is being done through training and workshops for leaders, but also for key staff personnel. This method of training leadership helps improve organisational context of the organisational model which focuses on developing shared values, shared beliefs, improved compassionate organisational practices, high quality structured relationships, and compassionate leadership behaviour (Workman & Hardin. 2014).

Training teams to work compassionately. The NHS is one of the largest workforces in the world with over 1.5 million employees (NHS Digital, 2018). However, the majority of interactions any individual staff member has is with their main team they are directly linked with. As such, developing team based compassion is crucial to implementing a compassion based model within organisations. Part of The Kings Fund paper 'Caring to Change: How compassionate leadership can stimulate innovation in health care' recommend providing training in compassion to all levels of individuals within an organisation (West et al., 2017). Increasing compassion in teams can create more focal actor which can help individuals through identifying suffering, showing empathic concern, acting compassionately, and engaging in sense making with those who require it in their team (Workman & Hardin. 2014).

Engendering compassion within individual workers. Individuals who work within healthcare service are generally considered to be compassionate individuals due to their choice of working within a caring profession. However, regularly these same individuals who apply compassion so readily in their day job to others struggle to apply this to themselves. Research suggested self-compassion is beneficial not just to work but to an individual's overall mental health (Abaci & Arda, 2013). Therefore, developing skills of self-kindness, experiencing common humanity, and becoming mindful can help individuals relate to each other within an organisation and become a more compassionate place to work.

Clinical implications

The main clinical implications of the empirical paper was that special measures is a confusing stressful process for staff and increased their sense of isolation and feelings of being unsupported within work. The elements reported by IMH nurses within the themes of the empirical paper are highlighted by Demerouti et al. (2001) as factors which can potentially clinically lead to burnout and increased levels of occupational stress, which in turn can lead to higher number of sick days. In Betsi Cadwaladr University Health Board in 2017, this led to 76,919 days of stress related sick days for staff (BBC News, 2018). As an increasing number of staff spend more time away from work due to these ailments based on their job role and what they are experiencing while undergoing major organisational change such as special measures, patient care is directly affected. This is because patients must wait longer for treatment or get a lower dose of talking therapy treatment than they require due to lack of available staff, which can lead to individuals becoming more unwell before services intervene (British Medical Association, 2018). Within mental health, this can mean service users progressing through services from primary, to secondary and finally to an inpatient admission, which is not only a negative experience for the service user, but also ends up costing services financially as inpatient admissions stays are some of the higher costs an organisation can incur (Personal Social Services Research Unit, 2015). This in turn adds to the overall costs to the NHS which creates more funding difficulties meaning fewer staff which increases workloads of staff already working within the service. This cycle continues until there is an effective intervention to prevent, reduce or treat burnout and occupational stress in staff. However, as shown by the literature review, there are very few studies with interventions which significantly reduce burnout and occupational stress in NHS staff, with no studies showing significant effects over the long term. Clinically this suggests that NHS

staff are in a difficult position if undergoing major organisational change as there is no established methods which significantly decrease occupational stress or burnout for staff.

Recommendations.

Clinically, NHS staff are an important but difficult to treat population group in terms of reducing burnout and occupational stress. Therefore, more resources should be focused on understanding the factors which make this population group hard to impact through burnout and occupational stress reducing interventions. Additionally, funds should be allocated to looking into providing either repeated short-term interventions which have been shown to be effective or finding and implementing focused long-term interventions which continually provide ongoing support to staff, potentially with a compassionate focus. If interventions which reduce or prevent occupational stress and burnout are ultimately impossible to implement successfully, more support should be given in treating occupational stress and burnout utilising evidence-based therapies which have shown effectiveness such as Cognitive Behavioural Therapy (Edelman, 2012) and Acceptance and Commitment Therapy (Harris, 2019). As suggested by West (2016), more funds should be provided for staff training to ensure that staff working within the NHS are high quality expert employees, and to increase the number of staff to share the workload. It is recommended managers should receive leadership training to understand how to manage staff dealing with high levels of occupational stress appropriately. Methods of doing this include providing appropriate discussions regarding changes in the work environment, and improved compassionate supportive supervision. Research should be conducted to analyse the impact of any potential implementation of the recommendations listed above, with details of the results given out across both front-line staff, senior management and executives to create whole organisation understanding.

Personal experiences

Being able to reflect is an important aspect within research and clinical practice but also in understanding how one learns best (Bennett-Levy & Thwaites, 2014). The focus of reflection is to notice difficulties with how an individual functions but also to recognise the wider picture when it comes to improving working and research practices, all while ensuring that mistakes once identified are not repeated (Bolton, 2010). As part of the process of reflection I kept a journal to record my thoughts and feelings about the research process. This allowed me to remain focused of my research, but also allowed me to appreciate times when I made important steps forward I may otherwise have not noticed. When completing qualitative research, it is important to understand one's own motivations and bias's and the journal allowed me to acknowledge some of these areas while ensuring I maintained focus on the participants perception of their experiences.

Throughout my clinical training and placements in mental health, I have always felt strongly about understanding the experiences of not only the clients I worked with but the staff and carers that support them. Working within a Health Board that was currently under special measures gave me an opportunity to try and understand staff perspectives of working under this phenomenon, an area currently not covered in the research literature. I chose to interview inpatient mental health nurses as they were on the front line of services, had a legal responsibility for patients in their care and were dealing with some of the most distressed clients within the service on a daily basis. Conversations prior to conducting the research also suggested this was an area which nurses discussed regularly but they had not been asked about often, considering special measures was normally viewed as a board and government level assessment. I hoped this research would be an opportunity to understand what staff who are working under special measures experienced.

Throughout this process it was regularly mentioned by members of other mental health professions that they personally did not see what effect special measures was having on their own practice and queried whether it would be hard to separate out the government's austerity measures being imposed on the NHS from special measures. These were topics discussed regularly within supervision, and following these discussions, I aimed to acknowledge and adapt my questions and analysis to accommodate these factors. I did this by focusing my questions on areas of special measures specifically, but also recognising in the interviews with participants that confusion over what was specific to special measures was a perfectly acceptable answer and that part of the process was merely to make sense of what their understanding was and not whether their answer was right or wrong. This alleviated some participants worries about the process and helped facilitate more detailed and open conversations which I felt benefitted the study by creating higher quality data from which to draw themes.

During the interviews, participants seemed to use them as an opportunity to vent about the difficulties they were experiencing which regularly meant going very off topic from the original question I had asked. Although this was an expected part of doing qualitative research, I recognised that in order to understand more about the impact of special measures, I would have to use my skills learned throughout training in clinical psychology to ensure that we maintained focus, but also that nurses were listened to about their difficulties. Particular stresses were difficult to hear as part of my role as a clinical psychologist is to help manage distress, but also be part of solutions for ensuring these issues do not arise in future. However, I had to maintain focus on the aim of the interviews was to record the experiences of the individual who was working under special measures and not let it become like a therapy session. Using supervision, I felt this was something I balanced well, but recognise it is always something in which I could do better.

Distance travelled during my research was extensive covering the length of North Wales regularly driving two hours on a daily basis and visiting wards outside of my contracted hours to ensure that I could meet participants when they would be available. At times I felt some journeys were a waste of time, however it was on reflection that even though I was not always recruiting on these trips, I was making useful contacts who helped meeting further individuals who would go on to participate in the study. This gave me an insight into how forming relationships are key in order to maximise coverage when trying to spread a message, whether it be research or clinical.

A key aspect of finally writing this theses is what are the intended implications of it and how does it contributes to the overall theory. This is something I have found maybe the hardest to recognise, not because I don't think the research is interesting and has its uses, but being so close to the data it can be hard to always recognise how another person reading it fresh may perceive its usefulness (or lack thereof!) and as such I am intrigued to see what a wider audience makes of it. My main thoughts around this are especially focused on the individuals who I am thankful to for giving up their time to speak with me. I feel for them that it is important their voices are heard, and I hope I do them justice in delivering that.

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Appendix H –Braun and Clarke’s (2006) 15-point checklist for good Thematic Analysis

Appendix A – University ethical approval

Ethical approval granted for 2018-16302 An exploration of clinical mental health staff's perceptio...



ethics@bangor.ac.uk

Wed 07/11/2018 12:25

David McNally ✓



Dear David,

2018-16302 An exploration of clinical mental health staff's perceptions of working under Special Measures within adult Mental Health inpatient services in the NHS in Wales.

Your research proposal number 2018-16302 has been reviewed by the School of Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Appendix B – NHS ethics approval



Mr David McNally
4 High Oaks
Bicton Heath
Shrewsbury
SY3 5AX

21 December 2018

Dear Mr McNally

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title:	An exploration of clinical mental health staff's perceptions of working under Special Measures within adult Mental Health inpatient services in the NHS in Wales.
IRAS project ID:	249969
Protocol number:	N/A
REC reference:	18/HCRW/0018
Sponsor	School of Psychology, Bangor University

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?

You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).



Email:
Research-permissions@wales.nhs.uk

IRAS project ID	249969
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It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document "*After HRA Approval – guidance for sponsors and investigators*" gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: David McNally

Tel: 07982718073

Email: david.mcnally@wales.nhs.uk

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **249969**. Please quote this on all correspondence.

IRAS project ID	249969
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Yours sincerely

Ann Parry (Health and Care Research Wales)
Permissions Service Manager (acting)

Email: Research-permissions@wales.nhs.uk

Copy to: *Dr Mike Jackson*
Ms Rossela Roberts, Betsi Cadwaladr University Health Board

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity certificate]		16 July 2018
HRA Schedule of Events	1	12 December 2018
HRA Statement of Activities	1	12 December 2018
Interview schedules or topic guides for participants [Draft interview guide]	1	12 November 2018
IRAS Application Form [IRAS_Form_16112018]		16 November 2018
Other [Employers liability and public and products liability certificate]	1	02 July 2018
Other [Transparency wording]	1	12 November 2018
Participant consent form [Consent form]	1	12 November 2018
Participant information sheet (PIS) [Information sheet]	1	12 November 2018
Research protocol or project proposal [Research Proposal]	1	12 November 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		12 November 2018
Summary CV for supervisor (student research) [Dr Nicola Robinson CV]		12 November 2018
Summary CV for supervisor (student research) [Dr Mike Jackson CV]		12 November 2018

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	Not applicable
4.3	Financial arrangements assessed	Yes	There is no funding to sites
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion	Not Applicable	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
	received for applicable studies		
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is 1 site type – All site activities – All activities listed in the protocol will be conducted at site

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS or on the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net, or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A local collaborator is expected at site

GCP training is not a generic training expectation, in line with the [HRA/HCRW/MHRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

IRAS project ID	249969
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No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix C – NHS Research and development ethical approval

IRAS 249969. Confirmation of Capacity and Capability at BCUHB NHS Organisation.



Sion Lewis (BCUHB - Research & Development) <Sion.Lewis@wales.nhs.uk>

Fri 04/01/2019 15:55

David McNally (BCUHB - Clinical Psychology) <David.McNally@wales.nhs.uk>; David McNally +3 others ∨



statement-activities- D.M 19....

729 KB

Dear Mr McNally

Re: IRAS 249969. Confirmation of Capacity and Capability at BCUHB NHS Organisation.

Full study title: An exploration of clinical mental health staff's perceptions of working under Special Measures within adult Mental Health inpatient services in the NHS in Wales.

This email confirms that Betsi Cadwaladr University Health Board has the capacity and capability to deliver the above referenced study, documents reviewed are those as listed in the HRA/HCRW approved list. **Please find attached the completed Statement of Activities** as confirmation.

We agree to start this study on the date of this email.

If you wish to discuss further, please do not hesitate to contact me.

Mr Sion Lewis
Cynorthwydd Ymchwil a Datblygu
Research & Development Assistant
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Tel: (01248) 384877 – Ext: 4877
Email: Sion.Lewis@wales.nhs.uk

Appendix D - Information sheet



An exploration of clinical mental health staff's perceptions of working under Special Measures within adult Mental Health inpatient services.

Participant Information Sheet

Introduction

We would like to invite you to take part in this research which aims to enhance existing understanding of clinical mental health staff's perceptions of working under Special Measures within adult Mental Health inpatient services. It is essential that you understand why this research is being carried out and what it will involve before you make your decision. We therefore request that you carefully read the following information before providing your consent.

What is the purpose of this study?

The National Health Service has always been scrutinised due to its role as a publicly funded body, but the use of 'Special measures' which is allocated to Health Boards or Trusts who require further support is a new phenomenon. As such, the impact this has on staff is currently unknown within the research base. Studies suggest inpatient mental health services has been highlighted as an area where staff experience high levels of pressure. Therefore, how special measures impacts this particular group is of particular pertinence to other services within the wider NHS, as well as the impact this has on their work with service users. My project wishes to explore staff member's thoughts on these processes and pressures, as well as their experiences of working under special measures.

Why have I been asked to take part in the study?

In accordance with the study criteria you have been identified as:

- Staff member of Betsi Cadwaladr Health Board who has experienced working under special measures within an adult Inpatient Mental Health Ward.

Do I have to take part?

Participation is entirely voluntary - it is up to you to decide to join this study. If you agree to take part, you will be asked to sign a consent form. You may withdraw from this study at any time, without giving a reason.

What will happen to me if I take part?

You will be invited to a one-to-one interview with the researcher, which will last around thirty to sixty minutes. Your interview will be audio recorded, for which you will be asked to give written consent. Following analysis of the interview data, you will be invited to discuss the findings of the qualitative analysis.

What will I have to do?

You will be invited to share your experiences and expectations of working under Special Measures within adult Mental Health inpatient services. The potential discussion topics will vary. A guide to potential topics for discussion is available on request. At the end of the interview you will be given the opportunity to discuss your participation including your thoughts and feelings about the interview questions.

Where will the research take place?

Interviews will be carried out within your work place away from your clinical setting in a room suitable for conducting an interview. Interviews can also be conducted over the phone if required.

When will the research take place?

The timing of the interviews will be a collaborative decision between the interviewer and yourself, mainly based around when you are free to take part.

What are the possible benefits of taking part?

This study hopes to provide you with the opportunity to share your experiences of working under Special Measures within adult Mental Health inpatient services. You are also eligible for a £15 Amazon gift voucher.

Will my participation be kept confidential?

All information, which is collected, about you during the course of this research will be kept strictly confidential. Throughout the study access to personally identifiable data will be restricted to the researcher and supervisors. All audio-recorded interviews and transcripts will be anonymised and filed in locked storage in a secure office building for the duration of the study. Following completion of the study raw data will be

destroyed. In order to convey your experiences accurately we would like to use anonymous quotes at random from your interview responses. You will be given the opportunity to review your interview transcript for errors.

What happens if I disclose something that may need reporting?

If disclosures are made during the interview that reveal the potential of threat or harm to yourself or someone else, this information will be shared with your line manager.

How do I withdraw?

You may withdraw from this study at any time by contacting the researcher during or after the interview using the details listed below with your name and contact details. Please note following the submission of a manuscript for publication the withdrawal of data will not be possible.

What will happen to the results of this study?

The data gathered during this study will be grouped, then analysed, and submitted for publication at a later date. It is also anticipated that the findings of this study will be disseminated through oral presentations delivered at seminars and conferences. The data may further be used to inform further research and used for teaching purposes.

What if there is a problem?

If you have concerns about any aspect of this study, you should contact the NHS research team or Bangor University using the details provided below. If you remain unhappy and wish to complain formally you can do this through the Betsi Cadwaladr Health Board complaints process by contacting the Health board and asking for the complaints department on 01248 384194.

(<http://www.wales.nhs.uk/ourservices/contactus/nhscomplaints>)

What will happen if I am harmed during this research?

In the event that something does go wrong, and you are harmed during this research, due to someone's negligence, then you may have grounds to take legal action for compensation against Bangor University or Betsi Cadwaladr Health Board, but you may have to pay your legal costs. You may also be signposted towards the relevant services for your problem. An information sheet attached provides information on advocacy, counselling or legal services.

Who has reviewed this study?

This research project is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. It has also been assessed by the Betsi Cadwaladr Health Board Research Department. This study has been reviewed and given a favourable opinion by the Bangor University Research Ethics Committee and Betsi Cadwaladr Health Board Research Department.

Thank you for taking the time to read this. It is hoped that the information provided above clearly answers any questions you may have about this study. However, should you have any further queries or require additional information, please do not hesitate to contact:

<u>Researcher Contact Details</u>	<u>Supervisor Contact Details</u>	<u>Academic supervisor Contact Details</u>
<p>Mr David McNally NWCPP School of Psychology Brigantia Building Bangor University Bangor North Wales LL57 2DG</p> <p>(m) 079882718073 David.McNally@wales.nhs.uk Sep84f@bangor.ac.uk</p>	<p>Dr Nicola Robinson Hergest Unit Ysbyty Gwynedd Penrhosgarnedd Bangor North Wales LL57 2PW</p> <p>(t) 01248 384091 Nicola.Robinson@wales.nhs.uk</p>	<p>Dr Mike Jackson NWCPP School of Psychology Brigantia Building Bangor University Bangor North Wales LL57 2DG</p> <p>(t) 01248 388746 mike.jackson@bangor.ac.uk</p>

Bangor University North Wales Clinical Psychology Programme: 01248 388 365
Betsi Cadwaladr University Health Board: 01678 520 542

Local services information:

Advocacy and legal information -

<http://www.wales.nhs.uk/sitesplus/900/page/48406>

Cruse Bereavement Care – counselling service. [01492 532268](tel:01492532268)

Stepping Stones – Childhood Sexual Abuse – [01978 352 717](tel:01978352717)

CAIS – Alcohol and Addictions Service, as well as employment and mental health support – counselling for individuals, couples and families, advice and support. [0345 061 2112](tel:03450612112)

Relate – relationship counselling, sex therapy, children and young peoples counselling, family counselling. [01492 533240](tel:01492533240)

Mind – counselling service provided by volunteers. [01745 336787](tel:01745336787)

Drop in service – Mind offers support to people in emotional or mental distress and helps people to improve their wellbeing. The service is open to all who wish to improve their wellbeing.

Opening Hours:

Monday: 9.00am – 2pm

Tuesday: 9.00am – 2pm

Wednesday: 9.00am – 2pm

Thursday: 12.00pm – 2pm

Friday 9.00am – 2pm

North Wales Carers Information Service – If you are providing help to or are looking after a friend, relative or neighbour with practical, personal or emotional support, find out how North Wales Carers Centre can help you with information and support [01745 331181](tel:01745331181)

Age UK Befriending Scheme – Neighbourhood Visiting Scheme – offering companionship support and friendship. [08000 223 444](tel:08000223444)

Samaritans

116 123

Participant Information Sheet transparency wording for Non-Commercial Studies

Bangor University is the sponsor for this study based in Wales. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Bangor will keep identifiable information about you until the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at URL:

<https://www.bangor.ac.uk/governance-and-compliance/dataprotection/documents/Data%20Protection%20Policy%20final%20July%202018%20v6.pdf>

or by contacting:

Governance and Compliance, Bangor University, Bangor, Gwynedd, LL57 2DG.
Phone: (01248) 382043

Bangor University will collect information from you for this research study in accordance with our instructions.

Bangor University will keep your name and contact details and any other identifiers such as job role confidential and will not pass this information to the NHS. Bangor University will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Bangor University and regulatory organisations may look at your research records to check the accuracy of the research study. Bangor University will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Bangor University will keep identifiable information about you from this study until the study has finished.

Appendix E – Consent form



CONSENT FORM

Title of Study: An exploration of clinical mental health staff's perceptions of working under Special Measures within adult Mental Health inpatient services

Name of Researcher: David McNally

**Please tick/
initial box**

1. I confirm that I have read and understand the Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.
3. I understand that data collected during the study may be looked at by individuals from the Betsi Cadwaladr Health Board and Bangor University, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
4. I understand that interviews will be recorded and that anonymous direct quotes from the interview may be used in the study report and may be used in subsequent publications.
5. I understand the data I provide may be used for research, teaching and potential research dissemination.
6. I agree to the use of audio recording
7. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

2 copies: 1 for participant, 1 for the project notes

<u>Researcher Contact Details</u>
Mr David McNally North Wales Clinical Psychology Programme School of Psychology Brigantia Building Bangor University Bangor North Wales LL57 2DG (m) 079882718073 David.McNally@wales.nhs.uk Sep84f@bangor.ac.uk

<u>Supervisor Contact Details</u>
Dr Nicola Robinson Hergest Unit Ysbyty Gwynedd Penrhosgarnedd Bangor North Wales LL57 2PW (t) 01248 384091 Nicola.Robinson@wales.nhs.uk

<u>Academic supervisor Contact Details</u>
Dr Mike Jackson North Wales Clinical Psychology Programme School of Psychology Brigantia Building Bangor University Bangor North Wales LL57 2DG (t) 01248 388746 mike.jackson@bangor.ac.uk

Bangor University North Wales Clinical Psychology Programme: 01248 388 365
Betsi Cadwaladr University Health Board: 01678 520 542

Appendix F – Semi-structured interview schedule



An exploration of clinical mental health staff's perceptions of working under Special Measures within adult Mental Health inpatient services in the NHS in Wales.

Rough semi-structured interview schedule

Introduction

Reiteration of information sheet and consent (Confidentiality etc.)

Purpose (this is about what it is like to work as a front-line staff member within an adult Mental Health Inpatient unit in an organisation that is under special measures)

Current situation:

- Could I start by asking you a little bit about your current situation?
 - What is your job role here?
 - What are our responsibilities?
 - How long have you worked here?
 - Where have you worked previously?
 - (if yes and somewhere else) Any major differences to where you have worked previously to here?

Understanding of special measures

- What is your understanding of special measures?
 - How did special measures come about in your opinion?
 - Has your opinion changes over time?
 - Have you been given much information on special measures and the progress?

Working under special measures

- What is like working under special measures?
 - How was it before special measures?
 - What are the key differences you have noticed?
 - Personally
 - Team wide
 - What do you think the impact has been on staff dynamics?
 - How has this impacted on management?
 - How has his impacted on your relationships with management?
 - How has this impacted n your relationships with other professions?
 - For service users
 - Impact on SU
 - Impact on your work with SU
 - Impact on staff in general working with SU
 - Are things better now under special measures?
 - Have things got worse under special measures?

Changes due to special measures

- How much change has this brought about?
 - Has the changes gone far enough?

Impact of observations within special measure examinations

- What are your thoughts on the additional observations required under special measures?
 - How has this impacted on working with other services (3rd sector etc.)?
 - What do you make of the media's observations of special measures within inpatient units in north wales?

Personal impact and opinion on special measures

- Do you find working under special measures stressful or helpful?
 - If stressful, what do you do to manage the pressures/stresses of work
 - What has helped?
 - What hasn't?
- If it was up to you, would you continue with the trust being under special measures or would you want it over?
- Do you think that the special measures process overall has been helpful and to the benefit of the trust?
- Do you feel it has benefitted your teams working practices?
- Do you feel it has benefitted your own working practices?

Appendix G – Coded transcript

<p>.... One thing that we are going to talk a bit about today is when you maybe noticed a change or when something kind of filtered down because prior to this the trust, the health board wasn't in special measures at the time. So what is your kind of understanding of special measures then?</p> <p>P: My understanding would be that as nurses that are on the front line that just get on and do the job it appears that its words that are handed down that the trust in special measures. The restraints that seemed to have come around from special measures seem to contribute to the shortage of nurses generally anyway, and how a health board in special measures is perceived has made recruiting very difficult, which has made pressures on the ward even more difficult to us on a daily basis. And I think the volume of patients and needs that are out there that services just aren't able to cope. Its not just here its throughout.</p> <p>I: Throughout?</p> <p>P: Throughout the trust I would say yeah.</p> <p>I: Because I was going to say because, you know information wise we have talked about kind of thinking handing down, what kind of things have you noticed that have been handed down?</p> <p>P: It regarding, it seems to be more to do with sort of finances really, the trust in special measures, its financial difficulties and then I think that's the impact then that has on staff and patient needs and that's how it affects everybody else.</p> <p>I: Yeah and that's quite a significant link isn't it really. With information that kind of gets down I guess do you feel that you as a staffing group are well informed about it?</p> <p>P: Probably not, because like I say its words that is just handed down, the trust is in special measures, but when you are on the front line, unless you are taking time to read those articles, or to read what is really going on, its becomes the environment that you are working with, the restraints that you have got, the situation that you are in. And from that that is just what you have to work with on a daily basis.</p> <p>I: Yeah, thinking about what you are working with on a daily basis, especially in comparison to maybe how it was before or kind of leading up to, special measures has been around maybe 3 years, so do you notice a difference between then or now? Or has it been quite a slow burn? Or is there?</p> <p>P: I think the difference is not being able to recruit staff, that there is a permanent post on there, like I say I have worked here a long time and always been quite happy, but this last week I have actually requested a secondment, and I have just been turned down because I can't have that, I cant apply for that because I haven't been released from the ward, because they haven't got the staff to cover me and they haven't, and because they have still got vacancies, a lot of vacancies within the unit that are still outstanding.</p> <p>I: So the impact on you being able to move on within the trust,</p> <p>P: I can't do it.</p> <p>I: No, if you apply for a completely new job,</p> <p>P: Which will then probably be temporary post somewhere, because I think that is the other thing as well isn't it? Where as you know, nursing was a career, a lifelong career, you generally had a permanent post, there was always other permeant posts out there. They are not doing that now, these posts were</p>	<p>SM due to financial pressures</p> <p>Shortage of nurses increase pressures on ward Services cant cope with volume of SU</p> <p>Financial issues around SM impact on staff and SU</p> <p>Time a barrier to understanding SM Get used to working in SM pressured environment</p> <p>Lack of staff under SM means current staff can't take opportunities</p> <p>Vacancies not filled under SM</p> <p>Nursing not a career now Only temporary posts available under SM</p>
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a temporary, you are covering sick, you are covering maternity leave, some body has gone elsewhere, you can cover incumbent, but you can't have that secondment because you haven't got any body to fill your post.

I: Yeah

P: So there is a huge impact.

I: So you said about covering sick, and covering maternity and things is that the main reason your incumbent doesn't seem to be available?

P: I think other people are taking the gamble, depending on their personal circumstances, and you know their situation of moving on and taking chances elsewhere, where opportunities are available that then they are able to take that gamble, and for myself when you have been doing it for a long time, when I came into the job, it was a case you stayed in a job and that was respected that you were in a job for a long time, but it seems now the more experience you have in various fields, the more likely you are to get the better posts. Not necessarily the experience, but it's a different experience you have got.

I: It sounds like you are suggesting that loyalty was seen as a valuable commodity?

P: But that's not the case now. It's been a huge step for me today to say I would like to do this, but I wouldn't want senior post here because people work above their grade, taking responsibility of the unit when other people aren't here, I think that a huge responsibility.

I: Is that something you have noticed that working above your grade?

P: Yeah, it gets to a point to the point where you have fewer senior individuals running the ward because managers can't be here and other people are needed elsewhere, so they are left running the ward. But its what you do, that is what has come on over the years.

I: Is that something you have noticed with the number of staffs on the ward now more often?

P: yeah, but you haven't got the volume of even band 5's to cover what you need to cover the basics.

I: you mentioned about problems with recruitment, why is that, is that something to do with special measures?

P: I think that something in general they have misjudged the situation, there was a reduction in the number of student nurses being recruited and that's had a knock no on effect, you have more teams being created over the years, so people have moved on or sideward because there are more opportunities out there rather than just being ward based.

I: Have you noticed nurses you have worked with taking the sideways steps?

P: A lot of nurses moved to other teams when they created other jobs in the community, it's a lot.

I: Do you think it has anything to do with the environment on the ward?

P: Yeah, because there has been situations where people have ended up with burnout on the ward, there has been incidents where people have gone I can't do that anymore and they have moved on to another job. Another nursing job, but just something that's not ward based.

Ability to move around impacts nursing career prospects

Loyalty not rewarded anymore

No secondment opportunities under SM due to low ward staff numbers

More responsibility on less senior staff

More responsibility on less senior staff

Can't cover basics due to staff numbers

Reduction in nursing training impacting ward

Other job opportunities reducing ward staff numbers

Burnout of nurses moved away from ward

<p>I: So its sounds like there is more increasing levels of stress, more options for nurses to go other places that aren't necessarily available to those who are willing to stick. How do you think special measure she impacted on other members of staff that aren't nurses and your interactions and your work with them?</p> <p>P: I think we are lucky here from management down to the housekeepers, they are part of our eyes and ears as well. Its part of what keeps you going because the job becomes very stressful, especially with the constraints you are under, but if you have a got a good working team it's easier to manage.</p> <p>I: what's makes the team a good one for you?</p> <p>P: A good ward manager, and sometimes I think it's the personality group you have got everyone wanting to do the same job, everyone wanting to go in the same direction, rather than in some teams where it can be a bit strict. The other thing that's tops people from leaving is because you work in a good team. Its part of the job that it is really stressful, but you are able to work together and support each other.</p> <p>I: What examples are there of how you support each other?</p> <p>P: It's just taking that timeout sometimes to make sure that your colleagues are ok, if something has happened, to make sure that there are no difficulties, different things for themselves, it's about keeping a look out for each other and look out for each other.</p> <p>I: How does that weigh up with the less time?</p> <p>P: It's like today, I have been working with another nurse, but we haven't really sent each other because we have both our heads down just working getting the jobs done, luckily the nursing assistants we have got on today are really knowledgeable and good at knowing what they need to do, but again that's good team working knowing your roles.</p> <p>I: Do you think students coming on to the ward, what do you think their perception has been of working in a add under special measures?</p> <p>P: I think that's some of them are quite shocked sometimes, we have a student with us, on the quieter days you are able to spend more time with them inspirit them, but on busier days we have been grateful that the student has picked up some menial tasks which they do need to learn to do as well, but that is not ideally what they should be here for but that's what we have to do sometimes to get through the day because obviously they are ,eat to be super numeracy, and then we apologise at the end of the day and say thanks for your help. Its how it is, this is the reality of the situation , when you get employed after you qualify one day, that you are not always, you are literally thrown into the deep end to get on with it. They have their preceptorship, but sometimes there is a bit of expectancy they are rushed through it and expected to complete it, because they are left on their own, some pick it up quicker than others, and some just aren't ready, and rightly so, it's a big ask.</p> <p>I: You mentioned about the bank system that both nurses use, is that something that is sued to back up the staff?</p> <p>P: This is how you think the trust don't manage their money effectively because when they are putting out to agency these agencies are getting paid an awful lot of money to come in and help us. Half the time we don't always feel safe around this agency staff because they don't know the ward, they don't</p>	<p>Teamwork helps manage stressful job</p> <p>Team working in same direction important</p> <p>Looking out for each other important</p> <p>Busy ward means team work important</p> <p>Students doing menial tasks to help ward but lose out on learning</p> <p>Students thrown in at the deep end</p> <p>Agency costs money and staff don't feel safe around agency staff who don't know how ward works</p>
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know the routine, they don't take on that risk and responsibility if something happens or if it goes wrong, they aren't the one in charge of that team, they aren't the one picking up the pieces, they aren't the one in charge that day. Then they stopped overtime which is a huge thing, how can some staff get paid overtimes and some areas not, and that's not being fair across the board. SO they have stopped our overtime and we have to work bank rates, so you are banking on the goodwill of staff to come in to continue to support the ward with staff that know your ward and your patients, which is still cheaper than paying agency staff. The have stopped agency now and have just bank. But you will find that people are interested in working the night shifts because there is extra money, like the weekend, and people don't want the day shifts because you don't get the extra money and you have more work in the day than you have at other times. SO people will pick and choose. For example, some people today are working their annual leave.

I: You mentioned about management and the chain of command. How do you feel about senior management handling of special measures in terms of your relationship with them?

P: Our ward manager is excellent, and gets very much involved in patient care, will help the staff and will come around and do ward rounds and do loads. Then you have got more senior members which change and then names are banded around and I don't really know who they are because they'll make decisions that come from the top which you have no control over anyway, that's how it feels, we had an issued with maintenance here, and if something went wrong it would be corporate manslaughter and that's on nurses heads, and you are like, hang one minute, that should be batted back up, surely? Not come down to us. They brought in extra staff in to manage the situation, and they even had nurses do maintenance checks which just sent part of the job role. I felt that the management were looking after themselves but not looking after the ward staff that already under stress and pressure from the patients, it's a lot. It doesn't really add up.

I: So you do you feel special measures has impacted on SU, do you think it's something they have noticed?

P: Its sometimes quite difficult to get people back out of hospital, that's happening with Home treatment teams trying to get someone off their books to be able to get one our patients out so we can get someone else in, we have had patients delayed in discharge because they haven't got the capacity to take anybody. Because other people can't take anybody, it has an impact on the wards then. For example last week they wanted to go Friday but they stayed till Sundays, so they are taking a hospital bed that someone else needs, but the community teams are short staffed as well.

I: What about carers of SU and something they have noticed and the impact of special measures?

P: I think sometimes, I don't think that people technically notice, I think that's sometimes the impact is noticed when someone needs a hospital bed and there is no hospital beds available and they have to go out of area and then you have people blocking beds because you can't get people out, and that impacts on everybody else.

SM relies on goodwill of staff working bank

Good ward managers muck in

Senior manager focus on avoiding risk to them but not under pressure nurses

Hard to move SU due to community being short staffed

SM only noticed by carers when people have to go out of area due to no beds

I: you have mentioned about other teams, do you think there has been any knock-on effect in terms of 3rd sector groups, because sometimes they are partly funded by the health board to come in, is that something you saw before special measures or not really noticed?

P: Do you mean like outside groups? Because its normally left to community staff to know what is out there, so we don't really know what's there.

I: So part of special measures I thinking about sometimes the extra observations that are made, do you feel there has been extra scrutiny of what happens here whether it be in terms of risk or paperwork or thing slice that? Do you feel there has been an increase in that level of observation?

P: I don't think so, going back, things were reviewed as things happen. Obviously the policy used to be every 3 hours, and then we decide that three hours was too long so that was changed to hourly, and then people are placed on 15 minutes and one to one observation.

I: SO it sounds like its been a helpful process to deal with the reactions of what has occurred?

P: Yeah, initially it's hard, oh god I have to do hourly observations again, but it does give you an insight and understanding of where somebody was, have they been off the ward, how long have they been off the ward for, at least you can calculate how long somebody has been off for. So it's more watertight, and then it sorts of raises standards.

I: DO you find working under special measures stressful?

P: Yeah it is, the job is stressful, because you just don't have the staff to cope with the capacity and demands of the ward and I think over the years the client group has changed, behaviours have changed and that's what has made it a bit more intense whereas you didn't used to get people ligaturing and self-harming as much as you do now. And more personality disorders and self-harming behaviours. And you get one patient bouncing off another, sometimes its about splitting people between wards because of the impact they are having on other SU. Its not always a healthy place to be.

I: DO you think the service has adapted to that well under special measures, or have they not had that opportunity?

P: I think that you are constantly reacting to situations, and sometimes it just feel like you are keeping you head above water, with who you have got and how you manage them.

I: That's sounds very stressful, what do you do that helps on a personal level, but also for the team that reduces level of stress?

P: I think it's having communication in the team and being quite vigilant of people who you know you have got problems with, but it just goes back to being supportive as a team, maybe somebody isn't comfortable with doing something, maybe somebody isn't happy doing the obs, so they swap with someone else, and dealing with particular person.

I: Do you think that special measures has heightened media observations of the health board or is it something that had not really factored in?

P: I don't think it's played the much of a factor I think it was we are in special measures that was some time ago now, and then you don't hear that much about it, it's what happened it's what it is, its how it is, but then you feel like that's management that have made those decisions, they've put the trust in

Working under SM stressful

SU population has changed so ward not a healthy place to be

Just keeping head above water

Communication helps manage stress

Looking out for each other helps ward staff manage

**Management responsible for SM but staff are penalised for it
Special measures caused by negligence**

Lack of staffing, temporary jobs, difficult to recruit due to SM

that situation, and everybody else is being penalised for it, but they are not. It's all happened due to their negligence and how they run the trust.

I: you said penalised for it?

P: That would be lack of staffing, the temporary jobs, not being able to recruit, people not wanting to work for the trust in special measures they would rather go somewhere else, not in Wales because Wales is behind England. There are more opportunities elsewhere. It's just becomes the norm. So when things get better in time, hopefully, it will be oh my god a full set of staff that day.

I: That brings me to something I was going to ask, do you think when special measures was over, is it something you want to be out of it or are you really not fussed?

P: You don't want that dark cloud hanging over the trust, it affects recruitment as well. I think that it comes down to not wanting to work in a trust in special measures, there may be better opportunities somewhere that isn't in special measures, everyone on temporary contracts more permanent work, job security, better morale.

I: Do you feel your practice has benefitted from being under special measures?

P: I don't think so, we have got enough without the extra stress on top, the extra restraints, shortness of staff, the demands our patients don't see that we are doing the best, but not having the time, but it's recognising that we do come through it. Things get better after the dark days.

I: Do you think the trust has benefitted from being in special measures?

P: Not really no. I think that someone has made a mess of things and there is a price to pay.

I: Do you feel there has been an opportunity for staff to use skills on the ward to make things better under special measures?

P: no, it's the reason that people have left, someone wanted to do further qualifications to use on here and they didn't get the chance, so they moved on.

New staff don't want to work in SM HB

**Practice hasn't benefitted from SM
Doing best with increased workload not recognised**

SM is the price to pay for HB mistakes

Lack of development opportunities meant staff left

Appendix H - Braun and Clarke's (2006) 15-point checklist for good TA

Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2.	Each data item has been given equal attention in the coding process.
	3.	Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.
	4.	All relevant extracts for all each theme have been collated.
	5.	Themes have been checked against each other and back to the original data set.
	6.	Themes are internally coherent, consistent, and distinctive.
Analysis	7.	Data have been analysed rather than just paraphrased or described.
	8.	Analysis and data match each other – the extracts illustrate the analytic claims.
	9.	Analysis tells a convincing and well-organised story about the data and topic.
	10.	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11.	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12.	The assumptions about TA are clearly explicated.
	13.	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14.	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15.	The researcher is positioned as <i>active</i> in the research process; themes do not just 'emerge'.

Word Count Statement

Section 1

Title Page:	46
Thesis Abstract	254

Section 2: Literature Review

Word count without references	15329
Word count with references	17689
Tables and figures	4400

Section 3: Empirical Study

Word count without references	10229
Word count with references	11313
Tables and figures	29

Section 4: Discussion Paper

Word count without references	4726
Word count with references	5419
Tables and figures	56

Appendices

Word count	9162
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Totals

Main text (excluding appendices, tables, figures and references)	19370
Appendices (including tables, figures and reference lists)	14314

Total thesis word count **33684**