THE DETERMINANTS OF WORKPLACE WELLBEING IN COMMUNITY MENTAL HEALTH TEAMS FOR OLDER PEOPLE AND SOCIAL CARE ORGANISATIONS

A thesis submitted to The University of Manchester for the degree of Masters of Philosophy
in the Faculty of Medical and Human Sciences

2013

ROWAN ELAINE JASPER

SCHOOL OF MEDICINE

List of contents

Word Count: 48,113

List of boxes, figures and tables

Boxes

Figures

Tables

The University of Manchester

Abstract of Thesis submitted by Rowan Jasper

For the degree of Master of Philosophy

THE DETERMINANTS OF WORKPLACE WELLBEING IN COMMUNITY MENTAL HEALTH TEAMS FOR OLDER PEOPLE AND SOCIAL CARE ORGANISATIONS

December 2013

Background: Workplace stress is a key topic of interest in literature, government policies and initiatives. Practitioners working in mental health and social care settings are at an increased risk of stress, especially social workers. However there is limited evidence on job satisfaction and wellbeing for those practitioners working in older people's teams.

Objectives: To investigate the key determinants of workplace wellbeing and other job outcomes for practitioners working in Community Mental Health Teams for Older People (CMHTsOP) and social care teams, including an exploration of the link between multi-agency working and job outcomes.

Method: A mixed method approach was undertaken, incorporating: A narrative literature review; analysis of data from two postal surveys of (i) care coordinators delivering adult social care services and (ii) members of CMHTsOP; and qualitative interviews with staff from multiple professional backgrounds. Quantitative analysis was in the form of statistical tests of association and ordinary least squares and logistic regressions.

Results: The literature review found that evidence regarding the impact of multi-agency working on practitioner wellbeing is not definitive, especially in relation to old age services. Quantitative analyses revealed that practitioners in multi-agency teams spent more time in direct contact with service users and less time in contact with other services; and also reported inferior supervisory support. Some practitioners being managed by a member of a different professional discipline also reported an imbalance between job pressures and autonomy, which is linked to stress. Yet the implications of multi-agency working for overall job satisfaction were not clear since these effects could be confounded by other variables. Qualitative interviews, however, found that most practitioners enjoyed working in more integrated teams due to improved access to social care services.

Conclusions: Multi-agency and integrated working brings both rewards and obstacles to practitioner welfare, with likely consequences for organisational morale, staff turnover and patient care. A revised causal model is proposed, integrating the key elements that shape workplace wellbeing. A challenge remains for organisations to improve the quality of supervisory arrangements in multidisciplinary teams, and for researchers to consider the broader impact of policy and practice reform on practitioner wellbeing and service users.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Copyright Statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the "Copyright") and s/he has given The University of Manchester certain right to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made **only** in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trade marks and other intellectual property (the "Intellectual Property") and any reproductions of copyright works in the thesis, for example graphs and tables ("Reproductions"), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://documents.manchester.ac.uk/DocuInfo.aspx?DocID=487), in any relevant Thesis restriction declarations deposited in the University Library, The University Library's regulations (see http://www.manchester.ac.uk/library/aboutus/regulations) and in The University's policy on Presentation of Theses.

List of abbreviations

ASW	Approved Social Worker
CIPD	Chartered Institute of Personnel and Development
CMHTsOP	Community Mental Health Teams for Older People
CMHN	Community Mental Health Nurse
DH	Department of Health
EASHW	European Agency for Safety and Health at Work
HSE	Health Service Executive
IB	Individual Budgets
IBSEN	Individual Budgets Evaluation Network
JCQ	Job Content Questionnaire
JDC	Job Demand Control model
JDC(S)	Job Demand Control Support model
PACE	Police and Criminal Evidence
SPSS	Statistical Analysis for Social Science

Acknowledgements

I would like to thank Professor David Challis for all his support and encouragement throughout my studies and my co-supervisor, Mark Wilberforce, for his patient support and enthusiasm. I am grateful to my advisor Professor Alys Young, who provided assistance and guidance at every stage.

I am especially grateful to the following people for their invaluable assistance: Angela Worden, my line manager, for her support and providing essential help with planning, chapter editing and organising the completion of this thesis; Sue Martin, who provided excellent support and assistance in formatting the full thesis; my proof reader Dr Deborah Brown who made helpful and considered suggestions; Dr Michele Abendstern for her qualitative methodological assistance and Dr Christian Brand for his statistical support.

I should like to give a very big thank you to all the health and social care practitioners who took time out from their busy schedules to complete questionnaires and participate in interviews.

I would also like to extend my thanks to all my amazing family and friends who have supported me throughout this period of study. I dedicate this thesis to my grandparents, Professor G.R. Coope and Dr B.M. Coope, as over the years they have supported me in my studies and research career whilst providing love and inspiration.

About the author

Rowan Jasper graduated from the University of Liverpool in 2004, having obtained an upper-second class BSc (Hons) in Psychology.

From 2006 to 2010 Rowan worked in the Biologics Register and the Pain Research Group within the Arthritis Research UK department at the University of Manchester. Rowan undertook all aspects of project work investigating musculoskeletal epidemiology, arthritis drug treatment and pain research on two large scales studies. During this time she also worked in prisons on the Isle of Wight, undertaking a needs analysis for prisoners focused on mental health and offender behaviour programmes.

In 2010, Rowan began her part time MPhil studies. For this she used secondary data and undertook a postal survey and interviews to identify determinants of workplace wellbeing among practitioners working in Community Mental Health Teams for Older People.

Since the summer of 2010, Rowan has worked for the Personal Social Services Research Unit at the University of Manchester. She has been a researcher for a large scale research project, funded by the National Institute for Health Research, exploring national trends and local delivery in old age mental health services. She is currently working on a study to explore and articulate care coordination arrangements for older people in the non-statutory sector.

CHAPTER 1: INTRODUCTION

In the UK, over 400,000 people are estimated to suffer from stress, anxiety or depression that was caused, or made worse, by their work (HSE, 2011). One recent survey found that stress and other related mental health disorders had overtaken musculoskeletal problems (e.g. back pain) to become the main cause of long-term absence from work (CIPD, 2011). Government statistics also indicate that stress consistently explains more days lost annually from work than any other cause (Blaug et al, 2007; HSE, 2011). National headlines in the media and world press often report workplace stress, a recent example being high stress levels can negatively impact on high profile cricketers' mental health and therefore their performance (Rice-Oxley, 2013). Stress is particularly common in health and social care organisations, with respondents to the Labour Force Survey that was nationally-representative, indicating a significantly greater prevalence of self-reported stress amongst these occupations than average (HSE, 2011). This is not unique to the UK, as similar findings are also detailed in wider European studies (EASHW, 2009).

This thesis is concerned with the determinants of work-related stress and job satisfaction amongst members of community mental health and social care teams providing services to older people. It has a specific focus on organisational structures that contribute to stress processes, particularly on joint health and social care working across agency and professional boundaries. This introduction sets the relevant policy and practice guidelines in context to better understand the background to the research and how these influence the work of health and social care practitioners. It establishes if there are any deficiencies in the existing evidence-base and details any outstanding research priorities and then addresses how this thesis meets these needs.

1.1 Research context: pressures for reform in health and social care

New public management

The ways in which mental health and social care services are delivered has undergone major changes in the last two decades, possibly beginning with the introduction of quasi-market reforms and care management (DH, 1989). The key source of these changes can be traced back to new public management and related organisational restructuring introduced in the early 1990s (Wistow et al, 1996). The changes were far reaching and comprised several clear dimensions, broadly agreed across the literature (Pollitt, 1995; Dunleavy and Hood, 1994). A key theme running through these reforms was a separation of traditional public services into delivery and 'enabling' roles, with a key principle that these undertake the task of "steering rather than rowing" (Wistow et al, 1996: p.18). Frontline services were increasingly driven by 'parent' agencies that used contracts as a way of specifying and monitoring delivery of services (Pollitt, 1995; van Thiel and Leeuw, 2002). These changes often required public sector workers to work to performance targets using quasi-objective measures of their input to the wider organisations' goals. These reforms were normally implemented as a way of reducing costs and with savings in mind (van Thiel and Leeuw, 2002). In parallel, senior management roles became more about ensuring enforcement and compliance of these performance targets rather than providing support and supervision (Beven and Hood, 2006).

For public sector workers the implications of "management by numbers" on job satisfaction and wellbeing soon became apparent (Hood, 2007). In particular for practitioners working in mental health and social care delivery these changes may have led to deterioration in the working environment (Parry-Jones et al, 1998). For those professions founded on delivery through the development of therapeutic relationships (Collins, 2008; Lloyd et al, 2002; Huxley et al, 2005), the reforms of new managerialism had the potential to change the nature of client contact. It was hypothesised that more time would be spent organising new services and arranging funding, and less time

would be available for traditional face-to-face work with service users (Postle, 2002; Lymbery, 2001). It has been claimed that many of the care processes have been reduced to standardised 'tick box exercises', and this has caused a growth in the amount of time spent completing paperwork and other administrative tasks (Jones, 2001; Coffey et al, 2009). Many of these changes have also coincided with wider organisational changes, instigated by both national government and local management, and these new policies and procedures may have led to the phenomenon of "innovation overload" (Coffey et al, 2009, Wilberforce et al, 2012). These changes may also have contributed to a sense of instability and lack of clarity in practitioner roles (Lloyd et al, 2002).

In particular, one practitioner discipline that may have felt the new public management reforms most keenly is social care. Ongoing changes to eligibility criteria have meant social workers are undertaking a greater role in financial assessments and in policing access to services than they previously did (Jones, 2001). Associated with this is an increase in the complexity of casework as only those people with more serious needs now receive services (Coffey et al, 2009). In addition, the separation of the *funding* from the *provision* of community social care services has led to an increase of new contracting arrangements, including the use of block contracts and increasingly standardised service requirements, that are organised through local authority commissioners (Knapp et al, 2001). A consequence of these processes has been the perceived limitation in the social workers' scope for implementing imaginative care packages (Wilberforce et al, 2012).

Personalisation and adult safeguarding: competing agendas?

Two additional areas of reform are worth mentioning because they are specifically relevant to community mental health and adult social care teams. First, beginning in social care, there is a growing trend towards the delegation of care budgets to service users. Against the background of increasingly standardised community care services some concerns have been raised that individuals are not able to receive the unique care package

that best meets their needs (Glasby and Littlechild, 2009). Since 1997 adult social care users have been able to receive Direct Payments as a cash budget to commission their own services, most commonly in the form of a Personal Assistant. This scheme was extended in the early years of this century to a wider range of service user groups, although the numbers using this scheme remained low. The principles of Direct Payments contributed to the development of the Individual Budgets Pilots conducted between 2006 and 2008. These aimed to give greater support to budget holders and to encourage a broader mix of service commissioning (Glendinning et al, 2008). However concern has been raised that they may pose an additional source of pressure on front line practitioners, including additional layers of paperwork and new IT systems, and they may require skills and experience that are not commonplace (Wilberforce et al, 2012).

Second, both adult community mental health and social care services have been the subject of increasing scrutiny, with respect to safeguarding those service users who are defined as 'vulnerable adults'. Beginning with the 1998 government commitment to design a new system that aims to do everything feasible to root out abuse and neglect in the care of vulnerable people, a range of multi-agency procedures have been designed and implemented across health and social care (DH, 1998; Manthorpe et al, 2009). Although such guidance may be helpful in improving adult protection standards, it has additionally raised concerns about new pressures and burdens being placed on front line practitioners (Rees and Manthorpe, 2010). These concerns may be worsened by an apparent blame culture and high profile media attention that is given to safeguarding concerns (Coffey et al, 2009; Taylor, 2006).

Integrated and multidisciplinary working

Successive governments have attempted to improve multi-agency working between health and social care services. These efforts are central to the delivery of community mental health services, and multidisciplinary Community Mental Health Teams for Older People (CMHTsOP) in particular.

In all but name CMHTsOP were first evident in the 1970s, and typically comprised a consultant in old age psychiatry leading a team of nurses. Others such as social workers and a range of allied health practitioners were also often included (Abendstern et al, 2012). Multidisciplinary working and CMHTsOP in particular, received new interest around the turn of the century through a range of initiatives and policy documents aimed at improving integrated care to older people. The National Service Framework for Older People established multidisciplinary mental health teams as part of government policy for the first time (DH, 2001) and a range of associated guidance and professional standards arose in following years from this (Royal College of Psychiatry, 2005; DH and CSIP, 2005). Recent evidence suggests a steady growth in multidisciplinary staffing amongst such CMHTsOP teams, with nurses, social workers, occupational therapists, support workers and, to a lesser extent, psychologists often being part of their composition (Wilberforce et al, 2012).

There is ample evidence from the literature that team structures and aspects of multidisciplinary working are important contributors to practitioner wellbeing (Buttrieg et al, 2011; Gulliver et al, 2003). Whilst multidisciplinary teams have been encouraged by government as a productive form of working, concerns have been raised that tensions can arise between professions especially in relation to boundaries between their roles and differing ways of working (Carpenter, 2003; Hughes, 2001). Recent developments in CMHTsOP may also pose challenges for health and social care practitioners, especially if 'distributed responsibility' (whereby consultant psychiatrists delegate control and accountability for service user care to other professions) under 'New Ways of Working' is implemented (CSIP, 2005). This may have implications for the pressures and rewards incurred by other team members.

1.2 The need for research

The reforms outlined above, and their potential to impact upon practitioner welfare, has important implications for care organisations and service users. Where workers experience work-related stress there is a clear link to worsening physical and mental health (Karasek and Theorell, 1990). There is also anecdotal evidence that stress contributes to presenteeism as much as absenteeism, in that many practitioners under stress will continue to work, without being well enough to do so (Caverley, 2007). Furthermore, there is a corresponding impact on service user outcomes, with stress impacting indirectly, through absenteeism and disrupted continuity of care noted above, and also poorer productivity and decision-making (Aiken et al, 2002, Karasek and Theorell, 1990).

Within health and social care organisations, there is as yet some limited evidence that team structure, design and composition are linked to stress and job satisfaction. However, existing research is predominantly descriptive and/or qualitative in nature, or restricted to small samples and individual service settings. Research showing how team design and changing organisational structures influence practitioner wellbeing is, consequently, in short supply: an evidence gap that this thesis seeks to address.

Specifically this thesis presents new research which aims to investigate key determinants of workplace wellbeing and other job outcomes in two samples of CMHTsOP and social care practitioners. The research has a particular focus on the importance of integration (between health and social care practitioners in teams) and multidisciplinary working in old age mental health teams. It investigates practitioners' views on workplace wellbeing using a mixed methods approach, with both quantitative and qualitative data analyses. The following chapters in this thesis are: a literature review of relevant publications; a methods chapter; three results chapters (two longer ones for each dataset and a shorter one for the combined dataset); and finally a discussion chapter is presented, considering both the limitations and future implications of this research.

CHAPTER 2: THE WORKPLACE WELLBEING OF MENTAL HEALTH AND SOCIAL CARE PROFESSIONALS: A NARRATIVE REVIEW OF THE LITERATURE

2.1 Introduction

Concern about worker safety and wellbeing has taken firm root in modern management theory and practice. With origins in the 1960s, a strong evidence-base has emerged within the occupational health literature, especially in Sweden and later in the US, initially focusing on physical wellbeing and decreasing hazards in the workplace (Karasek and Theorell, 1990). This literature had a profound impact on government policy: in the UK, the *Health and Safety at Work etc Act* 1974 provided regulation and guidance for both staff and employers, aiming to enhance worker safety. Across subsequent decades, greater attention has been paid to workplace stress, which has been shown to have profound impact on both physical (e.g. the risk of cardiovascular disease) and mental wellbeing (Karasek and Theorell, 1990). Social workers and mental health practitioners are two staff groups known to be at particular risk of workplace stress (Lloyd et al., 2002), which is likely to be associated with higher turnover rates and poor productivity. There remains, however, uncertainty and ambiguity over why mental health practitioners and social workers are so prone to stress, with many competing hypotheses being put forward. A particular interest of the present study is to explore the extent to which multidisciplinary working impacts upon job satisfaction and job characteristics linked to stress levels and ultimately worker wellbeing.

This is important because high stress levels in the workplace can often lead to an increased shortage of staff, as stress has been found to be the biggest risk factor for staff leaving their work (Coffey et al, 2004). Reflecting this, the Audit Commission produced a report, 'Recruitment and Retention - A Public Service Workforce for the twenty-first century' (Audit Commission, 2002). Poor staff morale in community care teams and low satisfaction levels risk rising costs occurring in economic terms through staff absences, and low

retention rates (Wykes et al, 1997). Stressful working conditions have also been found to lead to poor mental and physical health (Health and Safety Executive, 2011). Stress-related absence is reported to result in approximately 187 million working days lost annually, costing the country £12 billion each year (Stuart, 2001). Across different occupational groups there are variations in absence rates and associated costs but it is clear that staff in the public sector are reported to have higher levels of sickness than staff in the private sector (Employment Organisation, 2000).

Research has shown that the quality of patient care is affected by the wellbeing and satisfaction of those staff delivering that care (Wykes et al, 1997). Workplace wellbeing and improved determinants of staff satisfaction, recruitment and retention rates can lead to better outcomes in terms of improved continuity and quality of care for patients. In a study of nurse burnout rates and quality of patient care internationally, higher levels of burnout were associated with lower ratings of quality of care (Poghosyan et al, 2010). In another study nurses with increased work burdens had negative outcomes such as higher burnout rates and lower job satisfaction scores. These negative measures impacted through staff showing decreased performance at work which led to a reduction in the quality of care (Aiken et al, 2002). One study that investigated recruitment and retention rates showed these can be dependent on workplace setting, and that different professional groups differed in what they perceived as a stressful work environment (McCrae et al, 2007).

This chapter presents a literature review that aims to synthesise the theoretical and empirical studies that investigated stress in social work and mental health services. Following an overview of the aims and methods, this chapter explores the general occupational health literature to bring together theories and measures that are used. One of the key components of these is the job demand and control model of workplace strain described by Karasek (1979). Further areas to be discussed are role conflict and ambiguity, the main model of worker burnout, and the extension of the job demands and control model with social support acting as a possible additional buffer to

workplace strain. The second main component of this literature review investigates the empirical studies in a systematic manner, with a particular application to social workers and mental health practitioners, including those relating to Community Mental Health Teams for Older People (CMHTsOP).

2.2 Aims and objectives

The aim of this literature review is to investigate the existing key theoretical and empirical research papers that relate to workplace wellbeing in health and social care staff working in mental health settings. There is a particular focus on multidisciplinary working and integration between health and social care staff and CMHTsOP. Key themes are identified and the objective of the literature review is to aid investigation into the determinants of workplace wellbeing for staff in both CMHTsOP and social care only services on the basis of a solid understanding of the current literature. Later chapters of this thesis then explore data collected in relation to the literature themes and policies.

2.3 Methods

Two approaches have been adopted within this literature review: firstly, a narrative exploration of well-known theoretical papers and books, including a range of classical texts in the field of occupational psychology; secondly, a more systematic search for empirical applications to the work of mental health and social work professionals. The review of theoretical constructs was undertaken by reference to key texts known to the author and supervisors, including works published by leading authors in the field of occupational stress processes and measures. This initial section begins with an overview of stress processes and key definitions. With respect to the empirical review, the author searched Embase, Medline and PsycInfo databases using search terms provided in Box 2.1. The search terms were entered into these databases supplemented by Google Scholar and snowballing of studies from bibliographies of included studies. Papers not in English and not from peer-reviewed journals were excluded from the review,

as were those not explicitly relating to mental health or social work professionals. The searches were undertaken to find studies between the dates 01.01.1975 to 31.12.2012.

Box 2.1: Search terms for searching electronic databases for empirical literature

Structured electronic database search topics	Search terms
Health and social worker staff in mental health teams	'Community mental health staff' OR 'social workers' OR 'Health staff' OR 'mental health' OR 'Multi-agency' OR 'agency' OR 'community teams' OR 'wellbeing' OR 'job satisfaction' OR 'job demands' OR 'job controls' OR 'burnout' OR 'role ambiguity' OR 'stress' OR
Health and social work staff in mental health teams plus working specifically with older people	A combination of the above search terms plus: 'older people' OR 'integration' OR 'CMHTsOP*

2.4 Conceptual overview and definitions

Key terminology can be found below to aid understanding of the theoretical underpinnings and measures outlined in the next section of this chapter. This section draws particularly on the conceptual work of Tom Cox and colleagues at the University of Nottingham (Cox, 1993; Cox and Griffiths, 2000; Cox et al, 2000; Cox et al, 2006) and their account of differing stress theories across various academic and regulatory bodies.

"Stress" is particularly difficult to define, and definitions have changed during the years that occupational psychology research has progressed. Early definitions equated stress with the degree of pressure perceived by an individual, called the "engineering model" (Cox and Griffiths, 2000). One study that further showed this approach commented that "… stress is that

which happens *to* the man, not that which happens *in* him; it is a set of *causes*, not a set of *symptoms*". (Symonds, 1947 cited in Cox, 1993: p.9).

However, it has since been well established that different individuals respond differently, and modern theories of stress and organisational psychology focus on the processes predicting responses to work-related pressure. Consequently, this literature review adopts a more modern definition that work-related stress is:

> "an emotional and psycho-physiological reaction to aversive and noxious aspects of work, work environments and work organisations. It is a state characterised by high levels of arousal and distress and often by feelings of not coping" (Cox et al, 2006: p2).

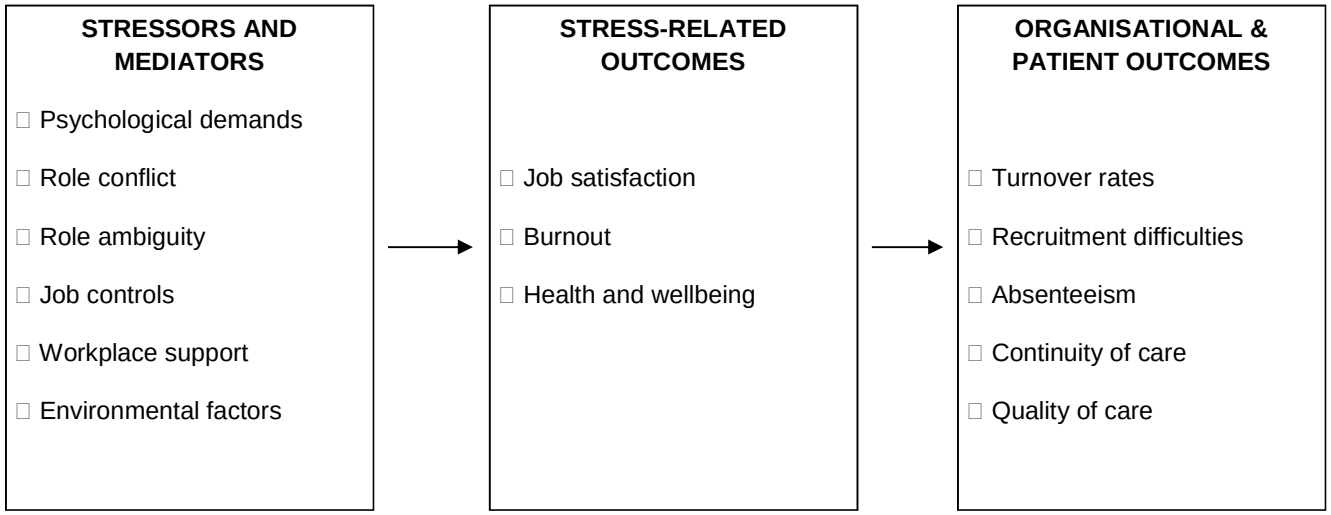
What is stated in this definition is that stress is a *reaction* to a set of personal and environmental circumstances. As such, a "stressful situation" is characterised not by its causes (e.g. high work pressures) but by the psychological and physical reactions that it generates within a person (Wilberforce et al, 2012). A common semantic technique within the literature separates the word "stress" (the reaction) from the word "stressors" (the triggers).

The definition recognises that there are many personal, job-related and environmental factors that mediate between stressors and the subsequent reaction in a person. Some features may be protective, whilst others intensify the effects of stressors. Modern theories of organisational wellbeing therefore focus on the *processes* that occur in the face of stressors; and what aspects of job design and mechanisms for organisational support can effectively protect (or "buffer") employees from psychological harm.

2.5 Causal model

A causal model outlined in Figure 2.1 draws on the above definition. It displays how all the sections of this literature review link together and forms a framework for interpreting the results of this thesis as a whole. It additionally acknowledges the organisational consequences of stress, and impact on patient outcomes. It is likely that there will be more factors than those originally envisioned which may refine this causal model in workplace wellbeing. Additional factors emerging from this literature review will be included in the discussion chapter.

Figure 2.1: Causal model of key determinants in workplace wellbeing for health and social care staff



2.6 Narrative review

Theoretical underpinnings and measures: an introduction

This section considers the theoretical underpinnings and measures of workplace wellbeing in health and social care staff. It discusses the job demand / control model (including a definition of stress), social support in relation to staff wellbeing, role ambiguity/role conflict and the concepts of burnout. It aims to discuss these competing hypotheses and introduces key terminology and ideas especially in regard to the measures used to test these hypotheses. These theoretical underpinning will give some support for the study findings in the subsequent empirical section 2.8.

Job demand –control (JDC) model

With their origins in occupational psychology, work stress models have been discussed at length in the literature. One classic model for exploring psychosocial dimensions of work is the job demand – control (JDC) model (Karasek, 1979). Within the JDC model, 'job demands' as a construct refers to the degree of mental pressure placed upon individual workers, such as being asked to do many tasks, working to unrealistic deadlines, being asked to shoulder high levels of responsibility, and facing conflicting demands. Critical in this is the individual's perception of their capacity to cope with demands, and the resources available to them (Parry Jones et al, 1998). In common with the definition of stress outlined above, stress is related to a negative psychological response to such pressures/demands (which may or may not result), but for this model any measures of job demands will measure the degree of pressure not the worker's psychological reaction to them (Wilberforce et al, 2012).

The model also looks at the construct of job decision latitude or 'job control'. This has two dimensions: *decision autonomy* is the extent to which an individual worker is permitted or able to make decisions about their work; and *skill discretion* which is the extent to which the individual worker can choose the skills they develop. In observing the job demands placed on the worker

and the degree of control the worker has over these demands, stressors of the job can be studied and the impact these may have on workers' physical and mental health observed.

Figure 2.2: Job demand/control model (adapted from Karasek, 1979)

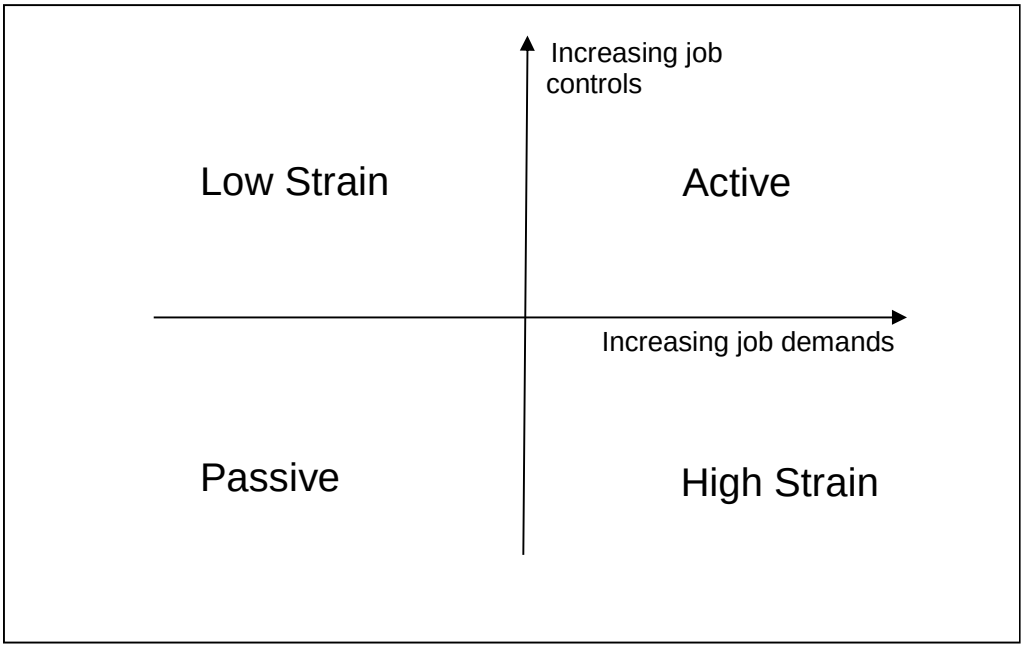


Figure 2.2 presents a common graphical presentation of the job demand/control model, adapted from Karasek (1979), with job demands along the x-axis and job controls along the y-axis. The model hypothesises that the most important determinant of workplace psychological health is not the levels of demand or control but more the balance between the two constructs (Wilberforce et al, 2012). That is, high demands do not necessarily lead to a decrease in worker's mental health. However where demand is high and control is low, there is a significant distance between work demands and the ability to meet them, which can lead to a higher risk of a range of physical and mental health problems. Karasek (1979) referred to those occupations with high demands and low control as 'high strain'. Karasek (1979) found that workers in the high strain group were six times more likely to report job dissatisfaction than others.

By contrast, another hypothesis of the JDC model is that a combination of both high demands and high job control will increase work motivation, learning and personal growth. Thus, for example, some surgeons face substantial pressure and responsibility in their jobs but have high levels of control which can alleviate high job strain. It is this type of active work that yields relatively positive reports of job satisfaction (Karasek and Theorell, 1990). This model has shown that workplace job strain can be greatly improved by changing the job demand and job control balance rather than just reducing job demands. This will have an effect on the way that workplaces and job roles are designed. It may not always be feasible to suggest a reduction in job demands so by increasing job control it provides another way of reducing workers' levels of job strain and therefore improving their mental and physical health, and wellbeing.

The other two quadrants in Figure 2.2 show the reverse of high strain and active occupations. Low strain jobs which combine low job pressures but with latitude over the work undertaken, are referred to in this quadrant as a sort of psychological paradise (Karasek and Theorell, 1990). Inactive occupations combined with low job controls are routine with equally low job pressures. This work quadrant lacks stimulation and staff do not have high job demands, but despite not being stressful, working in these jobs is not satisfying.

Social support construct

Social support is seen as one of the key elements in protecting individuals from stress (Weiss, 1974) and is regarded as reflecting emotional support (providing sources of motivation or sympathy) and instrumental support (providing direct assistance or advice in tasks being conducted) received from colleagues. One of the main critiques of the original JDC model (Karasek, 1979) was that the social support construct and its effect on workers' job strain was not included. In a model of environmental stress (Payne, 1979) the balance was investigated between three sets of variables: job demands, supportiveness, and job constraints, with regard to stress levels of workers. It was suggested that predictions between the demand

and control constructs would be more powerful if supportiveness was investigated as an additional construct. LaRocca (1980) investigated whether social support acted as a "buffer" against the effects of job strain. Pinneau (1975) found mainly negative associations between social support and job stressors and mental and physical health. The study did however find that with increased supervisory support lower levels of job stressors were reported, such as role conflict and ambiguity, and improved workload and skill utilization occurred. A study by House et al (1979) also investigated supervisory support compared to that of co-worker support, and they found little evidence of a buffering effect from co-worker support.

Given these conflicting reports, the impact of occupational stress on job related strain and health and the role of the perceived social support hypothesis was developed further in a study by LaRocca et al (1980). This study reviewed and analysed the data used by Pinneau (1975) using similar methodological techniques. Perceived job stressors included role ambiguity, work overload, job complexity, inequality of pay and poor skill utilization. The aim of the study was to observe if perceived emotional support buffered the perceived impact of job stressors on job strain and the impact of this on workers' mental (anxiety, depression), and physical health. This study showed there was some support for the social support buffering hypothesis on workers' mental and physical health but not in relation to reducing job related strains. They also found that buffering effects could be partially due to co-worker support. From these findings it was concluded that different organisational factors should be considered when looking at the social support buffering construct. In addition the types of support should be considered with clear distinctions being made between supervisory and co-worker support, and external support to the job.

Further research into the role of workplace social support was developed by Johnson and Hall (1988). The JDC model was expanded with the addition of social support, called the Job Demand-Control-Support model JDC(S), and it was hypothesised that the jobs with high demand and low control and also low in social support at work (referred to as "iso-strain" in the JDC(S)

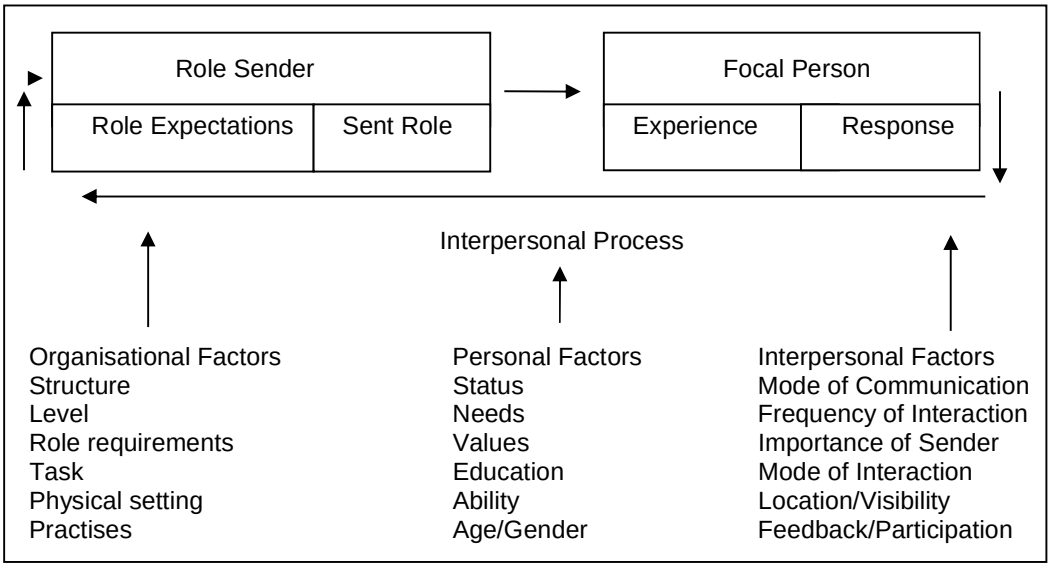
literature) would carry the highest risk of mental and physical health problems. The research found a greater risk of cardiovascular disease amongst workers in high strain jobs. The findings also suggested that lower demands, higher control and higher social support were associated with reduced prevalence rates of cardiovascular disease. Despite methodological limitations, this research suggests that social support plays a role in the new JDC(S) model and the study helps to address the criticism of the original Karasek model.

Van der Doef and Maes (1999) undertook a narrative review investigating the JDC(S) model hypothesis in relation to psychological wellbeing in the workplace. In this it was stated that the group of workers partially at risk of acute stress were those in iso-strain jobs. This hypothesis is interesting as most health and social care staff in older people's mental health teams work in high job strain roles. The JDC(S) model suggests that social support acts as a protective 'buffer' against the psychological impact of working in such high strain occupations.

Role conflict and role ambiguity

Another set of theories shaping workplace dissatisfaction are role conflict and ambiguity constructs with roots in classic organisation theory (Davis, 1951). Role theory can be articulated as follows. A 'role' can be defined as a set of expectations applied to the person of a particular position by the person and by role senders within and beyond an organisation's boundary (Banton, 1965). To examine this The Role Episode Model is used (Kahn et al, 1964), as shown in Figure 2.3.

Figure 2.3: The Role Episode Model (adapted from Kahn et al, 1964)



This model describes the processes between the worker (the focal person) being set expectations by the role sender (e.g. manager, supervisor, co-worker). It also includes additional aspects that affect the role, such as organisational factors of role requirement and level in the organisation, and personal factors across all professional levels of age and gender. The interpersonal factors include communication between the focal person and the role sender and physical location amongst others. All three of these factors affect the role episode by influencing the focal person/role sender, and when discussing role conflict and ambiguity this model can be used to investigate which of these factors have the most significant effect (Kahn et al, 1964).

Role theory hypothesises that a hierarchical chain of command (with a single, clear line of authority from top to bottom) should be more satisfying to work in. This is due to less ambiguity for the worker and this should facilitate increased productivity. This links up with the theory of “unity of command” (Davis, 1951) where workers receive tasks from one supervisor only and clear expectations are communicated about their role. Role conflict occurs when either competing instructions are received or where instructions conflict

with the value-basis of the individual worker. This role conflict can be compounded by poor communication between supervisors and the performance levels that are expected of an individual and hence role ambiguity occurs in the form of unclear and vague instructions (Van Sell et al, 1981). In both instances, role theory suggests that workers will experience stress and dissatisfaction and will perform less effectively (Kahn et al, 1964; Rizzo, 1970). Individuals in a role may have to perform in ways contrasting to their value systems or in a way different from what the organisation expects of them in their role.

In a study by Bliese and Castro (2000) role clarity was discussed in relation to the job demand-control-support theory. They proposed that relationships between job demands and strain will vary as a function of role clarity (similar to control). The findings confirmed that the relationship between demands and strain was affected by role clarity. Specifically, they found that a clearly specified role does relieve the stress consequences of high job demands, but that this 'moderating' effect was only present when effective social support was present. It is interesting to explore role conflict and ambiguity in relation to the JDC(S) model and how it fits into the Karasek model. Himle et al (1989) found that staff experiencing high role ambiguity were more likely to have higher stress levels, experience less workplace wellbeing and increased rates of absenteeism. Regarding higher levels of social support and supervision, these can act as intervening and moderating factors between burnout and job satisfaction. Emotional support from both supervisors and co-workers is associated with lower levels of burnout, work stress and mental health problems (Acker 2003).

Burnout theory

A final conceptual framework exists within the literature that is separate from the above theories in that it relates to a clearer understanding of how exposure to stressful situations can lead to acute psychological distress. "Job burnout" occurs when a worker has experienced prolonged exposure to workplace stressors and these excessive demands on the worker's energy lead to them experiencing feelings of failure and exhaustion (Freudenburger,

1974). It can be more clearly defined as “a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do ‘people-work’ of some kind” (Maslach and Jackson, 1981: p.99). Further to this definition, burnout has been described as a particularly important phenomenon observed especially in human service occupations involving working and dealing with emotionally demanding individuals and settings (Kim and Stoner, 2008). Professionals working with individuals with complex mental, physical, or social care needs can often experience feelings of increased stress in trying to resolve these complex situations. With complex cases and high demands staff can experience frustration in trying to resolve problems due to insufficient resources and lack of control. These can lead to staff feeling demoralised and using up their emotional reserves, and feeling exhausted (Maslach et al, 2003). Deterioration in the quality and amount of care given by the staff to service users can occur and high rates of job turnover, absenteeism and feelings of low motivation can lead on from this burnout state (Maslach and Jackson, 1981).

When exploring the concept of role clarity and role ambiguity it is interesting to focus on the literature for health and social care staff and multidisciplinary working. Multidisciplinary working and service integration levels will be carefully considered in this thesis as this is a key focus of current government policy and there are guidelines on the composition of multidisciplinary teams. It is useful to compare outcomes among multidisciplinary team members with both health and social care staff such as in some CMHTsOP with staff in single disciplinary teams (just health or social care but not mixed). Further in this literature review a brief discussion examining whether working across disciplines leads to higher or lower levels of job satisfaction, and therefore wellbeing, for practitioners can be found. Of value is to observe how multidisciplinary teams work and whether this has any effect on levels of workplace stress and burnout rates. Where there are clear team aims and objectives the need for the roles of all staff members to be understood is essential to facilitate effective joint working practices. This was highlighted in a study by Cameron and Lart (2003) where it was seen as imperative for every member of staff from different disciplines to understand their role within

the organisation for effective working patterns to occur. This is examined further in section 2.8 where health and social care disciplines are discussed in greater detail.

2.7 Measures

Finally in this account of theory-based material, a number of measures were identified. These are summarised in Table 2.1. They are by no means an exhaustive list, and simply reflect the most common measures tied to each concept. It is nevertheless helpful to provide a brief overview, since they are widely used in the empirical research, introduced in section 2.8.

Table 2.1: Measures associated with key concept theories

Concept	Measure and source	Description
Job demands	Karasek: Psychological demands	Part of the Job Content Questionnaire discussed in Chapter 4 and 5.
Job controls	Karasek: Decision latitude	
Social support	Karasek: Social support	
Role ambiguity	Rizzo: Role ambiguity scale	30 items covering ambiguity and conflict
Role conflict	Rizzo: Role conflict scale	
Job satisfaction	Andrews and Withey: Job satisfaction	Single item measure, usually with 7 response options on a Likert scale.
Burnout	Maslach: Maslach Burnout Inventory	Includes separate sub-scales for "depersonalisation", "emotional exhaustion" and "diminished personal accomplishment".

To investigate this topic many research studies use the Job Content Questionnaire (JCQ) which is an instrument for comparing psychosocial job characteristics and uses all three constructs from the JDC(S) model: job demands, control and support (Karasek et al, 1998). It also has an additional scale, job insecurity, which might reflect the changing labour dynamics in the current recession. The scale has been validated for the numerous versions available and it appears to be an important tool for exploring levels of worker wellbeing (Karasek and Theorell, 1990).

To measure role conflict and role ambiguity, a 30-item scale has been found to have high construct validity and has continued to be used in studies (Rizzo et al, 1970). However, a study by Van Sell et al. (1981), suggested that the best measures of role conflict are job dissatisfaction scales and job-related tension, using the focal person as the main component of self-report subjective testing. The authors concluded that, until more is known about individual reactions to stress levels, both perceived and objective measures of stress should be used to determine role conflict and ambiguity.

Job satisfaction can be linked to workplace stress and is usually measured using a single-item, standardised rating of "satisfaction with your current job", and rated using the seven-point 'delighted to terrible' scale (Andrews and Withey, 1976).

Finally, the Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1981) was devised to meet a need for an instrument to measure burnout rates among a wide range of human service workers. As has been suggested from the literature, there has been marked variations in rates of recruitment and retention, high job turnover, absenteeism and low morale among staff in these disciplines and the MBI has become the gold standard to measure burnout (Schutte et al, 2000). The MBI has three components: *emotional exhaustion* (feelings of being emotionally over-extended and exhausted); *depersonalization* (cynicism, negative and excessively detached responses from the service user); and *diminishing personal accomplishment* (feelings of incompetence and lack of achievement). When healthcare professionals undergo periods of prolonged stress they can experience burnout and this scale was found to have high reliability and validity as a measure of burnout, and has been used widely across all staff in health and social care disciplines (Maslach and Jackson, 1981).

2.8 Determinants of wellbeing: empirical papers

Preliminary determinants of workplace wellbeing and stressors as indicated by the literature review are outlined below. Any common themes identified in the empirical papers have been elaborated and discussed in relation to the theoretical underpinnings and measures already discussed.

Following the database search, 247 possible titles were identified and from the hand searches an additional 38 possible papers were found. Of these 132 abstracts were reviewed as these met the inclusion criteria of health and/ or social care staff and elements of satisfaction, wellbeing, and burnout. Eighty nine were excluded because they did not relate directly to staff views and although they met key search terms, were not directly relevant to the aims of this thesis. A total of 47 full papers were reviewed. A further 17 were excluded as they were not specifically related to staff working in mental health fields. Thus, there were 30 papers with key themes included in the empirical section of the literature review. Of these 30 papers only four studies met the inclusion criteria for the structured search with staff working in community mental health teams, specifically working with older people (See Box 2.1). These will also be discussed below in the key themes.

Social workers and mental health practitioners

Repeated studies have found that social workers and mental health social workers in particular are at risk of job-related stress. One study found that stress scores were highest in large samples of workers in social services amongst those staff with lowest job satisfaction scores and control over their work (McLean and Andrew, 2000). In another study, mental health social workers who felt undervalued at work experienced excessive job demands, (using the Karasek measure), and those with limited control in decision-making scored lower on job satisfaction scales and displayed other aspects of burnout (Evans et al, 2006). Higher emotional exhaustion was associated with higher job demands, and a sense of personal accomplishment was

associated with greater latitude or independence in decision making (Evans et al, 2006).

The main determinants of high rates of stress and emotional exhaustion for these social workers appeared to be high job demands, low control and workers not feeling valued for work done (due to newer organisational structures). Both social workers' skills and role, and how different people within multidisciplinary teams perceive their skills, have changed (Balloch et al, 1998). For mental health social workers, it is argued that the role is very strongly client based and members of staff who work in these areas are often involved in complex care and conflict-resolution (Kanner et al, 1978). A large part of a social worker's role is perceived as "being there for the client," and this close working can lead to job satisfaction but also exposes social workers to high levels of stress due to conflicting demands (Huxley et al, 2005). Job autonomy has previously been defined as the "control over the individual's own immediate scheduling and tasks" (Liu, Spector and Jex, 2005: p326). Lack of autonomy is believed to reduce personal accomplishments in work leading to a depersonalised attitude with some evidence linking job autonomy to burnout and job turnover (Kim and Stoner, 2008). Findings from this work suggest that role stress and burnout levels are high when job autonomy is low, so control is an important determinant in workplace wellbeing.

As previously noted social work is a strongly client-based profession so the workers are involved mainly in complex social situations and have many demands in their work (Lloyd et al, 2002). Social workers may also have greater sensitivity to client problems than other practitioners which may cause them to be increasingly vulnerable to work stress (Kanner et al, 1978). In both the health and social care professions there is now increasing emphasis on targets and meeting frameworks / deadlines, and decreasing emphasis on the work of individuals, and these targets and frameworks appear to conflict with social workers' core values (Borland, 1981). Social workers thus often experience little control over what they see as the nature

and length of contact, the expert functions they carry out and the value placed by others on their work (Dillon, 1990).

The changes in social policy and legislation that have been outlined in Chapter 1 can also adversely affect both health and social care workers' wellbeing. It has been noted that devaluation of practise skills and well as cutbacks in support and supervision have not reduced burnout rates (Balloch et al, 1998). It has been hypothesised, though not proven, that many of these policy changes have had a detrimental effect on the specific tasks that social workers undertake. Whilst this may be outside the scope of this literature review, Chapter 4 details associations between time use and job characteristics. In multidisciplinary team working, especially with the CMHTsOP often containing social workers, these extra stressors may have an additional effect on all staff wellbeing in such teams.

In a study by Marshall and Barnett (1993) there were variations in reported levels of job strain between nurses and social workers employed in differing work settings. This indicated that different work settings can have an impact on levels of job strain and therefore wellbeing for nursing and social worker staff. As Huxley et al (2005) noted, job satisfaction levels are linked to stress scores, and in roles with lower levels of job satisfaction and control over work higher stress scores were reported. This makes job satisfaction an important measure when looking at levels of stress, as high stress may lead to decreased feelings of workplace wellbeing. Since job demands normally cannot be reduced in the short term due to organisational factors and job demands are set by higher level staff to meet targets and policies, one way to alleviate the impact these have on staff wellbeing may be to investigate levels of control in work and the ways in which new staff policies can improve these levels. In the Karasek JDC model demands may not be reduced but the level of autonomy and control staff have over these may alleviate their effects on job strain (Karasek, 1979).

Role conflict, role ambiguity and conflicting demands

As organisations undergo growth and change, previously established work practice is superseded by new processes, workers' roles can run the risk of overlapping (Lloyd et al, 2002). In particular, with multidisciplinary working roles can become ambiguous. If role conflict is experienced it intensifies the levels of burnout and job dissatisfaction reported by staff (Um and Harrison, 1998). In a study of community mental health workers across a multidisciplinary team work characteristics were investigated in relation to caseload factors and psychological wellbeing. Multiple regression analyses showed that community mental health practitioners reported improved wellbeing where their caseloads comprised clients with greatest need. This counterintuitive result is explained by the positive association between client need and role clarity (Walsh and Walsh, 2002). Role clarity is therefore another important factor when considering worker wellbeing.

The appropriate role for social workers in partnership and integrated working settings has yet to be identified, and there remains a sense of role ambiguity in the social work role within mental health teams for older people (Lymbery, 2006). Practitioners experiencing role ambiguity have been found to report lower satisfaction and poorer psychological health than those with a clearer role (Balloch et al, 1998). In another study, social workers with a higher degree of role ambiguity and role conflict associated with organisational change reported reduced perceptions of personal accomplishment, which has been linked to stress and burnout (Lloyd et al, 2002). In a qualitative study, social workers were again found to be preoccupied with the difficulties they had in defining their role in relation to staff of other professional backgrounds (Reid et al, 1999). Role ambiguity and role conflict can clearly be seen to play a significant part in staff wellbeing for both health and social care mental health professionals.

Social support, co-worker and supervisory support

Factors that have been found to protect mental health staff from burnout include the presence of supervision and support, autonomy and job variety in older people's settings (Spear et al, 2004). In addition, members of staff reporting increased job satisfaction tended to have increased productivity, reduced absenteeism, better retention and lower rates of burnout. In a recent study staff reported high burnout rates when social support is low (Kim and Stoner, 2008). Stressors linked to poor staff wellbeing include lack of supervision and working with ever-changing multidisciplinary staff and professional groups. From a study of social workers who had greater supervisory supervision and co-worker support, these staff were less likely to show burnout, as measured by the MBI, than those staff who had less supervisory support and co-worker support (Siebert, 2006).

Studies with CMHT members from different professional backgrounds have previously reported that contact with team colleagues and multidisciplinary working were the most rewarding part of their job, in addition to working with clients and being "clinically efficient" (Onyett et al 1997). From these studies it can be seen that social support can have a buffering effect to alleviate stressors and which links with the extended JDC(S) Model (Johnson and Hall, 1988). A further study collected measures of job demands, control and support from mental health staff across a variety of different settings, including community mental health teams. The findings showed that having supportive relationships (in combination with low levels of job demands and high levels of job control) led to better wellbeing scores (Wood et al, 2011).

Environmental factors

Environmental factors are stressors that are intrinsic to the job itself, such as staff workload and administration issues, problems surrounding time management, safety issues relating to potentially violent and suicidal clients, lack of funding and high worker turnover rates. Most of the stressors associated with high burnout rates in staff are related to these environmental

factors (Evans et al, 2006). In a study of Community Mental Health Nurses (CMHN), the impact of care management practises were explored and findings showed increases in stress and decreasing job satisfaction scores were associated with increased workload and administrative duties combined with reduced time to see service users and other family contacts (Parry Jones et al, 1998). These decreased job satisfaction scores and high stress levels could, in theory, if left for a longer period of time lead to staff burnout and increased rates of absenteeism.

Another study investigated differences between hospital and community based mental health staff in relation to work stress and job satisfaction scores. Important sources of stress for community mental health staff were increased workloads and administrative burdens (Prosser et al, 1996). A review of the literature of stress and burnout amongst CMHNs concluded that the top three stressors for these staff were increased workloads, administration and problems with time management (Edward et al, 2000). A study investigating job satisfaction and burnout levels in CMHTs found that lack of resources and work overload was the major source of stress for staff (Onyett et al, 1997). This was also found in qualitative interviews with mental health staff who worked with service users experiencing significant distress. One study showed that staff felt the most challenging aspects of work were system processes rather than the client group they worked with (Priest et al, 2011). Hence, it would seem important when considering all the other determinants of wellbeing that care is taken to ensure that environmental and organisation factors around the workplace are also included.

CMHTsOP practitioners appear to prefer community-based work since they had increased involvement with patients and greater autonomy and this was perceived as a more rewarding environment than shift work in inpatient wards. Staff also felt they had individual skills and professional backgrounds that led to them feeling they were unique in the team and could give a certain amount of specialist expertise when working in mental health teams for older people (McCrae et al, 2007). Equally, it has been suggested that social workers can also feel satisfaction with their work and with the correct

organisational support can have rewarding and fulfilling careers (Collins, 2008). This thesis aims to address some of the organisational factors that may contribute to successful work environments including team structure, supervisory support and job role design.

There are currently numerous organisational changes occurring in both health and social care organisations, and joint working procedures, integrated services and teams being developed with a large drive towards multidisciplinary working. In addition to these organisational considerations influencing staff wellbeing is the one aspect that might have been overlooked by previous studies, which is the impact on the care that the service users receive, if staff experience high stress levels.

2.9 Quality appraisal

All studies were observational and as such run the risk of bias in inference. Inevitably, given the context of this research there were no randomised controlled trials and a standard quality measure was not employed across different studies. Lloyd et al (2002) noted particular concerns about study quality and stated that the range of stress measures used across different studies made it difficult to compare findings. Even when measurements were the same, different scoring methods could be used and some studies developed their own instruments to measure stress, thus making comparisons difficult across studies (Edward et al, 2000). Hence both input and output measures vary greatly in the literature. Many studies are cross sectional in design and it was stated in numerous studies that there was a need for more longitudinal research to look at the effects of stress and burnout on work performance, job satisfaction and absenteeism over time with the same group of responders (Acker, 2011; Edwards et al, 2000; Evans et al, 2006). Another limitation was that studies tended to have small or unrepresentative samples with low response rates. The literature appears focused upon, mental health nurses, with relatively few studies of some other staff groups (e.g. occupational therapists) which make the literature findings harder to generalise (Edwards et al, 2000; Onyett, 2011).

A second area of concern relates to the method employed. The separation of job content from the characteristics of the person themselves is problematic in explaining stress and burnout. These factors are likely to be determined by an interaction of person and job content. Hence, a weakness in the causal pathway (in Figure 2.1) is the link between the first and second boxes, since relevant personal traits, likely to be linked to a susceptibility to stress, are rarely measured. Self-selection and factors external to the job may contribute to higher stress levels experienced by mental health social workers (Evans et al, 2006). It is worth noting that personality profiles and values are likely to vary between different professional groups. Thus social workers may focus more on social injustices than health professionals. Therefore the perceived stressors that social workers report may be related to these rather than aspects of the job itself (Lloyd et al, 2002). More general measures of psychological wellbeing could be included to identify personal factors that may impact on stress, such as respondent's health and attitudes towards the role (Acker, 2011).

Over four or more decades, studies have examined the relationship between job content and stress outcomes with broadly consistent outcomes, but, for reasons noted earlier, these cannot be seen as definitive. Given these concerns, the link between boxes two and three in the causal model (Figure 2.1) is necessarily even more problematic. Whilst burnout, stress and absenteeism/ turnover are closely linked, the quality of care and service user outcomes are much harder to determine and little evidenced. As a consequence the model in Figure 2.1 is principally a conceptual organisational tool.

2.10 Discussion and conclusions

The literature review has examined the stressors that affect staff wellbeing with particular emphasis on health and social care staff working in the mental health field. An interesting finding from the literature is that there are relatively few research studies on health and social care staff working in mental health and a particular gap in the evidence base regarding those

caring for older people. The structure of CMHTsOP are still changing due to recent government policies (Chapter 1), so that a modest evidence base might be expected. A recent study has indicated many differences in CMHTsOP across the country in their structure, staff mix and how they operate in practice (Wilberforce et al, 2010

Subsequent chapters of this thesis will analyse the determinants of staff wellbeing using different datasets. The IBSEN dataset (Chapter 4) and CMHTsOP dataset (Chapter 5) are used to investigate the impact on job outcomes of working in single discipline versus multidisciplinary teams. As has been discussed in the literature, mental health social workers appear to be at a higher risk of burnout due to less professional recognition or poor support in their roles. The link between team composition, multi-agency working and job characteristics are the central focus of this study.
Most of the studies cited in this literature review had problems with small sample sizes and low response rates. The dependent variables used also varied considerably across the majority of the studies in this literature review, so it is hard to accurately compare like-with-like studies. Standardised scales such as Karasek and the job dissatisfaction scale have been used in the analyses in this thesis with the aim of investigating workplace wellbeing in health and social care staff in different settings. This contrasts with the majority of the literature identified in the review which used qualitative measures. Additionally, in the current study CMHTsOP staff were interviewed and these transcripts assist in unravelling important effects for different professional groups, especially among the multidisciplinary teams.

CHAPTER 3: AIMS AND METHOD

3.1 Introduction

This chapter provides an outline of the thesis aims, key research questions, and provides details of the methodologies adopted. Most importantly, it outlines the three central components of this thesis, which are:

1. Secondary analysis of the "Individual Budgets" dataset, consisting of a postal survey of care managers providing services as part of a pilot of self-directed support conducted in 2007 (findings presented in Chapter 4);

2. A new postal survey of care coordinators working in a sample of community mental health teams for older people (CMHTOP), conducted in 2010 to 2011 (findings presented in Chapter 5);

3. Analysis of a merged dataset, combining selected cases and variables from both the Individual Budgets and CMHTOP datasets (findings presented in Chapter 6).

The chapter explains these data sources and the key measures used in the postal surveys (including a discussion of screening and data quality checks, missing values, variable construction and coding) before then providing a description of the analytical procedures undertaken.

3.2 Aim and research questions

The aim of the thesis is:

> *To investigate the determinants of workplace wellbeing and other job outcomes in a sample of community mental health and social care practitioners, with a focus on the importance of integration and multidisciplinary working in old age services.*

More detailed research questions were identified, as shown in Box 3.1 together with the key data sources used to address them. In summary, two research activities have been undertaken. First, secondary analyses of staff questionnaires from an evaluation of Individual Budgets (IBs), based upon a national social care pilot of the approach.

Box 3.1: Research questions

Research Questions		Data sources used
1. Are integrated working practices associated with differences in:		
	(i) Patterns of practitioner time-use;	Individual Budgets dataset
	(ii) Psychosocial job content;	Both Individual Budgets and CMHT datasets
	(iii) Job satisfaction;	Both Individual Budgets and CMHT datasets
	(iv) Intent–to-quit?	CMHT dataset
2. What aspects of integrated working facilitate/hinder positive staff outcomes?		Qualitative staff interviews with CMHT members

Second, the collection and analysis of staff questionnaires and face-to-face interviews from members of Community Mental Health Teams for Older People (CMHTsOP) as part of a National Institute for Health Research (NIHR) funded project entitled “National Trends and Local Delivery in Old Age Mental Health Services: Towards an Evidence Base” (Challis et al., forthcoming). Both quantitative and qualitative research methods are discussed. Further details of the data sources are provided in Table 3.1.

Table 3.1: Summary of data sources used

	Individual Budgets dataset	CMHTOP dataset *
Time of data collection	2007	2010-2011
Nature of data collection	Self-completed postal survey	Self-completed postal survey
Sample size	249 respondents	295 respondents
Response rate	29%	59%
Setting	13 English local authorities	38 CMHTsOP in nine Mental Health Trusts across England
Relevant service user groups	Older people Adults with mental health problems People with physical and sensory impairment People with learning disabilities	Older people with mental health problems
Key variables	Basic demographics Karasek job demands, controls and social support Job satisfaction Diary activity tasks	Basic demographics Karasek job demands, controls and social support Job satisfaction Intent-to-quit
Purpose of data collection	To examine the pilot phase of implementing individual budgets upon staff satisfaction and job characteristics.	To explore the relationship between personal and team characteristics, with a focus on the degree of integrated working, and staff wellbeing and better/worse job outcomes.

*In addition to the postal survey questionnaires, 24 in-depth interviews were undertaken with practitioners in nine mental health trusts. These are discussed in section 3.5

3.3 The Individual Budgets data

This section of the chapter relates to the use of the secondary dataset taken from the Individual Budgets pilot that was carried out across the UK between 2005 and 2007 (Glendinning et al, 2007). This pilot explored the roll-out of Individual Budgets to adult service users across 13 local authority social services working with adults and employed a mixed method approach. Of relevance to this thesis, the study explored the effect of delivering Individual Budgets and the impact on professional staff responsible for implementing these. At this national level 13 teams were initially observed but these were subsequently reduced to 12, since in one team there were two social workers whose sole job was to work with Individual Budget holders, and including this team might have led to problems with generalisability of the findings. Some of the teams involved were multidisciplinary teams (comprising health staff and occupational therapists as well as social workers) and the others social

care staff only teams. The respondents to the survey were social workers and other care managers who delivered Individual Budgets to a wide range of adult service user groups: older people, younger adults with physical disabilities, adults with learning difficulties and a smaller number of adults with mental health problems. Similar teams were chosen from each local authority that had no involvement in the Individual Budgets pilots. These comparison teams were matched for the four main adult care service user groups outlined above. Further detail of the data collection is provided in Glendinning et al (2008).

Key measures

A questionnaire was given to staff to self-complete, including a brief section on general background questions, relating to personal, job and team characteristics (Appendix 1). The questionnaire was returned by 249 respondents (29% response rate). The schedule included the Job Content Questionnaire (JCQ) which provides measure of psychological job demands, control and social support (Karasek, 1979; Johnson and Hall, 1988), as summarised in Box 3.2.

The job control measure in the JCQ consists of the two scales, “skills discretion” and “decision authority”. In addition, the social support measure consists of “supervisory support” and “co-worker support”. JCQ is a reliable and consistent tool and has been tested many times across national boundaries and professional backgrounds (Karasek and Theorell, 1990).

Box 3.2: Karasek domains

Domain	Description
Psychological demands (job demands)	Five items measuring perceptions of the degree of work-related pressure: ● "work fast" ● "work hard" ● "no excessive work" ● "enough time" ● "no conflicting demands"
Skill discretion	Six items measuring the variety of skills that the respondent can develop and deploy in the job: ● "learn new things" ● "repetitive work" ● "requires creativity" ● "high skill level" ● "variety" ● "develop own abilities"
Decision authority	Three items measuring perceptions of control over key decisions affecting respondents' work environment: ● "allows own decisions" ● "little decision freedom" ● "a lot of say"
Decision latitude (Job control)	A weighted sum of skill discretion and decision authority
Co-worker support	Six items, measuring perceptions of (instrumental and emotional) support from colleagues: ● "co-workers competent" ● "co-workers interested in me" ● "hostile co-workers" ● "friendly co-workers" ● "co-workers work together" ● "co-workers helpful"
Supervisory support	Five items, measuring satisfaction with support from managers: ● "supervisor concerned" ● "supervisor pays attention" ● "hostile supervisor" ● "helpful supervisor" ● "supervisor good organiser"
Social support	A weighted sum of co-worker support and supervisory support

Source: adapted from Karasek et al, 1998.

The JCQ has not been widely tested with practitioners from health and social care backgrounds and this will be considered in Chapter 7. Two other Karasek sub-scales that have not been fully validated were not employed in the analysis.

The questionnaire also used a single-item job satisfaction scale with 7 response options in a Likert scale ranging from terrible to delighted. Higher scores indicated greater levels of contentment with work. There has been some debate whether job satisfaction and dissatisfaction are at either end of

a single continuum, or if they are conceptually different constructs with different underlying causes (Warr et al, 1979). Nonetheless, the findings of research with single-item/multi-item satisfaction scores have tended to concur empirically (Wanous et al, 1997) so this job satisfaction scale was used as a key outcome variable for this dataset.

A diary study was also conducted as part of the same schedule. This required respondents to record their main activities in half hour intervals throughout the working day, for a period of one week, as described in Box 3.3.

Diary studies have a long history as a mechanism for recording time use in community health and social care teams. In addition to the Individual Budgets pilot, examples of their use include assessment of time-use in community mental health teams for older people (von Abendorff et al, 1994), evaluation of care management arrangements in different settings (Weinberg et al., 2003; Jacobs et al., 2006; Challis et al., 2007), evaluation of intensive care management for older people (Tucker et al., 2008), and as part of the evaluation of IT initiatives in the Common Assessment Framework for Adults (Challis et al., 2011). For the purpose of this thesis the diary study provides useful measures of staff activities focussing upon the domains of work with service users and carers, interaction with services, and other activities.

Box 3.3: Task categories collected from the Individual Budgets diary study

Activity category	Tasks undertaken
Direct contact with service user	● interview with service user ● complete assessment documentation with service user ● carry out financial assessment ● counsel service user ● discuss care options ● accompany service user on appointments or visits ● add further information to assessment by telephone contact with user; review care package in person ● review care package by telephone
Direct contact with carer	● gather assessment information from carer ● assess carer's own needs ● provide advice and support to carer
Service contact (related to the service user or their carer)	● information exchange – multidisciplinary team ● gather information prior to assessment ● gather assessment information from health services staff ● gather assessment information from other agencies ● gather information from existing user records ● complete benefit form for user ● complete assessment documentation back in office ● other office-based paperwork related to caseload ● discuss cases in supervision with manager ● negotiate and arrange social services for service user ● negotiate and arrange health service for service user ● monitor social service provision ● monitor health service provision ● review care package in conjunction with other agencies
Social service procedures and organisational commitments	● administration and reading of departmental documents ● team meetings ● developing new services/changing existing services ● training ● dealing with telephone enquires ● filing ● faxing ● photocopying ● travel (four task: service user related travel; carer related travel; service related travel; and other travel) ● approved social worker (ASW) duties (three tasks: application for admission to hospital; report writing; police and criminal evidence (PACE) interviews)

Source: adapted from Jacobs et al (2013)

Data management

Permission to use the Individual Budgets dataset was obtained from the original investigators and supplied in a single SPSS database. The data was already cleaned, labelled and prepared for analysis, and appropriately anonymised. Key measures including the Job Content Questionnaire were already derived, although these were double checked to ensure the correct weightings had been applied, and permissions received from the original

author (Karasek et al, 1998). The original job satisfaction score was reversed so that higher scores indicated more contentment with work as it was considered that this change would provide greater clarity when reporting the findings.

3.4 The CMHTsOP staff questionnaire data

The staff survey was designed to investigate variations in staff status, wellbeing and job characteristics across different CMHTsOP. This was part of a wider body of work funded by the National Institute for Health Research (NIHR) forming a final report investigating national trends in service delivery across CMHTsOP (Challis et al, forthcoming). The thesis author was a joint author of the study report, and played a key role in the design and data collection relating to the "CMHTOP dataset".

The relevant data for this thesis were obtained from a self-completed postal survey distributed to all 38 CMHTsOP within nine Mental Health Trusts that were participating in the main stage components of the study. To enable comparisons to be made across team type, short telephone interviews with team managers were completed in each CMHTOP prior to the survey. These interviews collected factual data about team composition and management, in addition to the nine standards of integration used in a previous national survey. Further details of these are shown in Box 3.4 (Wilberforce et al, 2010). These nine indicators were added together with one point per "yes" response to determine the level of integration for each team included in the survey. For the purpose of analysis, teams were categorised into "high", "medium" and "low" integration teams based on their score on these nine items.

Box 3.4: Nine indicators of integration

1. Single point of access used regularly?
2. Single location?
3. Single care plan across health and social care?
4. Single care coordinator across health and social care?
5. Do staff from different professional disciplines conduct initial assessments? If yes, do they use the same assessment documentation?
6. Are all assessments and notes from different professions held in the same user record/file?
7. Team leader manage all core staff (excluding medics)?
8. Shared access between health and social services service user records?
9. Health staff able to commission social service packages?

Source: Wilberforce et al, 2010

The paper-based, anonymised questionnaire was piloted with two members of staff from one team, before being distributed via mail-out to all participating teams in September 2011. A second mail-out was conducted in October/November to non-respondents, with fieldwork closing in December 2011. Completed questionnaires were returned in freepost envelopes to the thesis author, who undertook the data entry and another member of the research team carried out a 10 per cent validity check to determine accuracy. Decisions on data entry were made jointly by the research team.

Measures and data

The self-administered questionnaire was designed to collect information on job outcomes, psychosocial characteristics of work and socio-demographic data. Two job outcomes were measured. The first was a single-item job satisfaction scale with six response options in a Likert scale ranging from "terrible" to "delighted". Higher scores indicated greater levels of contentment with work. The second was a new outcome measure on respondents' intent-to-quit. This was derived from two items on a four-point Likert Scale ranging from "strongly disagree" to "strongly agree", capturing thoughts about leaving the current post ("I often think about quitting my current job") and actual job search underway ("I am actively looking for a new job").

With respect to psychosocial job characteristics, the study adopted the same Job Content Questionnaire as described in section 3.3 above in the IBSEN study. However, a new derived variable was calculated to reflect the *balance* between job demands and job controls. As outlined in Chapter 2, the primary hypothesis posited by Karasek (1979) is that job demands and controls interact. More specifically, high job demands combined with sufficient job control are less detrimental to wellbeing than when high job demands are combined with limited job controls.

Following Courvoisier and Perneger (2010), a new variable was calculated as the simple arithmetic difference between the job demand and job control variables. Respondents reporting low scores on this variable faced an imbalance between demands and controls (relative to other respondents) and were likely to be most at risk from stress and burnout.

The questionnaire (Appendix 2) also collected information on a range of personal and job characteristics, including age, gender, job title, length of time within the team, length of time in mental health services, and caseload size. The analysis aimed to investigate the personal, professional and team characteristics associated with job outcomes and psychosocial job content. In keeping with the research questions, particular attention was paid to the associations between team integration and these key variables. The number of returned questionnaires was 295 with a response rate of 59 per cent.

Data management

Data was collected as part of the wider study which received ethical approval on 3rd August 2010 (Research Ethics Committee Reference: 10/H0306/43). Data was entered, cleaned, labelled and prepared for analysis. Key measures including the Job Content Questionnaire were derived with the correct weightings being applied, and permissions had previously been received from the original author (Karasek et al, 1998). As with the Individual Budgets dataset the job satisfaction score was reversed so that higher scores indicted more contentment with the work to improve clarity when

reporting the findings. All analyses were completed as per the analysis plan in section 3.7.

3.5 Qualitative methods

Whilst the quantitative analysis seeks to examine whether multidisciplinary working and/or service integration is associated with job outcomes, it does not address why this may be the case. Consequently, the second thesis research question explores what aspects of multidisciplinary and integrated working facilitate/hinder a positive working experience; a question better addressed by qualitative methods. Semi-structured interviews were conducted as part of the NIHR-funded research investigating the service user outcomes associated with different CMHT models. These were conducted to provide detailed information on ways of working across all nine CMHTs participating in the study, but indirectly provided a valuable source of information that may contribute to a greater understanding of staff job characteristics and wellbeing.

Interviews were undertaken with a sample of CMHTOP practitioners (including community mental health nurses, social workers, occupational therapists, support workers and clinical psychologists) by four researchers, including the thesis author, between January and August 2011. Each interview was conducted face-to-face and lasted approximately one hour. Interviews were audio-recorded with consent, and professionally transcribed. In addition to questions about how their teams worked, the interviews explored a number of the themes relating to the pressures and rewards of working in their particular team, the extent of autonomy experienced, the quality of the support they received both from colleagues and managers, and the nature of their professional identity (Appendix 3). These data from 24 interviews, spread across nine CMHTsOP, were included in the present analysis. The nine teams were categorised into two groups based on their degree of integration. First, co-located *health and social care teams*, with either a single manager (Teams A, C, D) or separate managers for health and social care professionals (Team B), were categorised as ‘high

integration' teams. Secondly, co-located *multidisciplinary health teams*, with either a single manager located within the team (Teams F, G, H, I) or a separate manager for different professionals located outside the team (Team E), were categorised as 'low integration' teams.

A thematic analysis of the transcripts was conducted using a framework approach to manage the data (Ritchie and Lewis, 2003). This is a systematic approach that remains grounded in the data, making use of emergent themes as well as *a priori* categories, those which have earlier been identified. This involved five stages: familiarisation with the raw data, developing a framework including key word searches e.g. support, autonomy, indexing (using Atlas.ti with multiple codes if necessary), charting these and finally the mapping and interpretation of emerging themes with any similarities and differences noted. The author, being part of the interviewing team, and those undertaking the initial analyses and the further framework analysis, was closely familiar with the data. Hence, any misinterpretations for the present study were minimised and validity ensured as much as possible. A detailed description of the qualitative data analysis, including examples of how the data from the interviews were coded and themes derived, can be found in Appendix 4.

This framework method strengthened the findings as it ensured that interpretation was not subjective and the analysis was grounded in the original data. These qualitative data findings provided a deeper insight into the themes of job demands, job control, supervisory and co-worker support, the balance between support and control, and job satisfaction, supplementing the quantitative findings, albeit for a smaller number of respondents.

3.6 Combined dataset

The final strand of analysis required merging both of the quantitative datasets in SPSS for Windows (version 20) to produce a combined dataset. The principal aim of this strand was to isolate those respondents from both studies working in a care management/care coordination role with older

people, and to compare the effects of working in single versus multidisciplinary teams. This materialised from earlier work undertaken by the thesis author and colleagues (Wilberforce et al, 2012) which found evidence that working with older people was associated with poorer job outcomes. However, the nature of the data precluded further exploration of this effect which is now examined in the context of a new larger dataset.

Specifically, a larger merged dataset was required to undertake these analyses because (i) in the IBSEN dataset, the overwhelming majority of participants who worked with older people did so in single disciplinary teams, and (ii) in the CMHT dataset, by definition, every participant was in a multidisciplinary team. Therefore, to compare participants working with older people in single versus multidisciplinary teams, a new larger dataset was created.

The merged sample was restricted to:

- Care managers working with older people from the Individual Budgets dataset
- Care coordinators (thus excluding team managers, consultants and administrative staff) from the CMHT dataset.

Consequently, the new merged dataset contained 366 cases, all working with older people in a care coordination/care management role. Discussion of the possible limitations of the analyses are reserved for Chapter 7.

Brief descriptive analyses were undertaken of the key variables of Karasek domains and the job satisfaction variable and these were explored in relation to multi-agency and single agency teams. Any differences between the two were noted and similarities commented upon.

3.7 Analysis plan

The data for all quantitative datasets were first analysed using comprehensive descriptive statistics (including appropriate means and measures of dispersion) and graphical representation of distributions, to describe the groups and the spread of key variables and characteristics. This permits consideration of how representative the samples were. Specific research questions were investigated through a mix of simple hypotheses testing and multivariate analyses. Further detail is supplied in Box 3.5. Parametric testing was undertaken given the large sample sizes. All tests were two-tailed, and conventional significance thresholds were adopted (Field, 2005).

Box 3.5: Hypothesis tests and further analysis

Bivariate tests of association
- Chi-squared test
- Independent samples t-test
- Analysis of variance (with Bonferroni post-hoc tests)
- Pearson's correlation

Regression analysis
- Ordinary least squares
- Logistic regression

3.8 Summary

This chapter has described the methods used in this thesis and described the use of self-completion questionnaires for both the secondary individual budgets dataset and the CMHTsOP staff questionnaire dataset. It has also explained the use of the diary study from the individual budgets dataset and a sub-sample of staff qualitative interviews from the CMHTsOP wider study. Data management issues have been addressed and future analyses have been listed and described. The next two chapters (Chapters 4 and 5) examine the findings from these analyses and Chapter 6 briefly discusses the findings from combining these two datasets.

CHAPTER 4: THE INDIVIDUAL BUDGETS DATA

4.1 Introduction

This chapter explores the secondary dataset from the individual budgets pilot study (Glendinning et al, 2007), with the aim of investigating if there were any key differences between staff satisfaction and staff wellbeing in two different types of teams, multi-agency and social care only teams. There are several sections in this chapter. First, a description of the dataset as a whole and the key variables is provided, with graphical distributions of these variables and descriptive statistics. Secondly, bivariate analyses are outlined, focussing upon team type, discriminating between multi-agency and social care only teams, and tests of association are conducted with salient independent variables, such as job satisfaction and the range of Karasek measures of job content characteristics (Karasek, 1979). Thirdly, regression models are detailed exploring the findings outlined in the first two sections. These models aim to explain the determinants of variation in wellbeing and satisfaction in two different types of teams and further unravel the content of any significant results found from these sections.

4.2 Description of sample and key variables

All variables and details outlined can be found in Box 4.1 at the end of this chapter. Each variable is described in detail and any computations and recodes that were necessary for the analyses are explained. The reason for such computations will also be outlined in the text, where relevant, so as to aid interpretation of the results. This provides a useful reference of the type of each variable and the differences from the original raw data variable are specified.

Questionnaires containing the job satisfaction, job content and demographic data for this sample were returned by 249 respondents, giving a response rate of 29 per cent. The dataset had been accessed as a secondary dataset and as explained in Chapter 3 the requisite permissions have been given

from the original research team that undertook the study. The author of this thesis worked on a copy of the dataset with all the raw variables listed to complete the analyses for this chapter. As it was a secondary dataset a large amount of research was invested in learning the origins of the original questionnaire and familiarisation with its structure, questions and variables. A copy of this questionnaire can be found in Appendix 1.

Personal and team related variables

Table 4.1 outlines an overview of key personal and team related characteristics from this sample as a whole. The following section has been divided into sub-sections by variables to describe all the variables and describe the spread of each in relation to the dataset. Any variations will be discussed and any interesting findings noted.

Age

Respondents were asked to complete their age on the questionnaire into a blank box, therefore making a continuous scale variable. The age variable was recoded into categories which are detailed in Table 4.1. The largest proportion of ages of respondents lay in the 35-44 category with 28.5 per cent and the 45-54 category with 31.9 per cent of responses. There were fewer responses for staff aged under 35 (22.1%) and in the older age category (fifty five and older) there was the lowest proportion of respondents with 17.4 per cent. There were only 17 missing values.

Gender

Respondents were asked their gender. In this dataset 75.2 per cent of respondents were female (see Table 4.1). There were 11 missing values.

Professional group

The professional group variable consisted of individual questions regarding professional qualifications, with possible multiple responses, since individuals could possess more than one professional qualification. The variables are

outlined in Box 4.1 and a brief description of each is provided. For the results presented in Table 4.1, basic descriptive data about the professional qualification variables are outlined. The proportion of respondents possessing a social work qualification was just over half (53.4%). The proportion of staff respondents that had a nursing qualification was 13.3 per cent. The proportion of respondents working in other allied health professions, such as occupation therapy (OT) and physiotherapy was 6.0 per cent. Those respondents reporting that they had no professional qualifications comprised 27.7 per cent. There were no missing values from these questions on professional backgrounds.

Employment status

Respondents were asked if they worked full or part-time and no further recoding of this variable took place in these analyses. The majority of respondents, 78.8 per cent reported that they worked full time, see Table 4.1. There were nine missing values for this variable which showed this was well completed.

Service areas

Respondents were asked if they worked in the following four service areas. These were: Older People; Physical Disabilities; Learning Disabilities; and Mental Health. Each of the four different areas were asked as an independent question and therefore the respondent could answer positively to one or multiple items. A breakdown of the results can be seen in Table 4.1 where the proportion of respondents who worked with service users who were older people was just over half, 50.6 per cent. The lowest proportion of respondents, with only 28.9 per cent, was found in the service area of mental health. The service areas of physical disability and learning disability had similar proportions of responses with 37.0 per cent and 35.4 per cent respectively. If all four categories had no recorded response, these were categorised as missing and the item as a whole would then be classified as missing. The total of these in the dataset was three.

Team type

Team type is one of the key variables of interest to the aims of this thesis and will occur frequently in the following tables in this chapter. Respondents were asked the question what type of team do you belong to and there were two answers available, either multi-agency teams or social care only teams. There was a lower proportion of respondents working in multi-agency teams, at 37.9 per cent, than in social care only teams, 62.1 per cent. Missing values for this variable were low at only 9 cases.

Team size

Respondents were asked to complete the size of the teams that they worked into a blank box, therefore making a continuous scale variable. The team size variable was recoded into categories which are detailed in Table 4.1. The proportion of respondents that worked in teams of ten or less members was 37.6 per cent. The middle two size categories of 11-15 and 16-20 had not too dissimilar proportions with 23.6 per cent and 15.0 per cent respectively. Respondents in teams that had 21 or more staff members comprised 23.6 per cent of the sample. There were 29 missing values for this variable.

Size of active caseload

This variable asked respondents for the size of their active caseload and was recorded as a continuous scale variable. This was subsequently recoded into categories that can be seen in Table 4.1. The highest proportion of responses fell in the 15-24 cases category at 34.4 per cent. The next category of below 15 comprised 29.9 per cent of the sample. A smaller proportion of respondents reported higher caseloads with the 35-44 category accounting for 7.1 per cent and the 45 plus category 5.4 per cent of responses. There were 25 missing values for this variable.

Missing values

Missing values were relatively scarce since the majority of respondents maintained a good rate of completion throughout the questionnaire. Missing information was rare in the age, gender, employment status and team type

variables. Although slightly more missing values were reported for team size and size of active caseload variables, at 29 and 25 respectively, it was decided that these numbers would not necessitate imputation to increase the numbers.

Data analysis training

As stated in the previous chapter the dataset came from a study undertaken by other researchers. The thesis author, after initial familiarisation with the data variables, mainly used the statistical package SPSS for windows (version 20) with additional statistical guidance where necessary provided by supervisors. They provided expert knowledge and informal guidance on variables to help the author undertake the analyses in this chapter. The author attended statistical training provided by the University of Manchester Cathie Marsh Centre for Census and Survey Research (CCSR) to further improve her knowledge of the statistical methods used throughout this chapter. This included Introduction to Statistics Parts One and Two, Multiple Regression Modelling and Logistic Regression training. Further informal training was provided by members of the supervisory team throughout the MPhil period when it was required. The research uses a statistical significance threshold of p=0.05.

Table 4.1: Respondents' personal and team related characteristics

		n	%
Age	<35	52	22.1
	35-44	67	28.5
	45-54	75	31.9
	55+	41	17.4
	Missing values	14	
Gender	Male	59	24.8
	Female	179	75.2
	Missing values	11	
Professional Group Qualification[†]	Social work	133	53.4
	Nurse	33	13.3
	Allied health professional	15	6.0
	None	69	27.7
Employment status	Full time	189	78.8
	Part-time	51	21.3
	Missing values	9	
Service area	Older people	125	50.6
	Physical disabilities	91	37.0
	Learning disabilities	87	35.4
	Mental health	71	28.9
	Total missing values	3	n/a
Team type	Social care only	149	62.1
	Multi-agency team	91	37.9
	Missing values	9	
Team size	<=10	83	37.7
	11-15	52	23.6
	16-20	33	15.0
	21+	52	23.6
	Missing values	29	
Size of active caseload	<15	67	29.9
	15-24	77	34.4
	25-34	52	23.2
	35-44	16	7.1
	45+	12	5.4
	Missing values	25	

Total of sample=249. [†]The total proportion of answers may not add up to 100% because of the possibility of double response (more than one category response) to this question.

4.3 Outcome variables

Job satisfaction outcome variable

The job satisfaction variable is a single-item scale asking respondents to rate how they feel about their current job on a seven item Likert scale. These seven answers range from “delighted” through to “terrible”. More details can be found in Box 4.1. In the original data the scoring was such that lower numbers indicated higher job satisfaction. For the purposes of this chapter it was felt that inverted scoring might be confusing so the scale was reversed to mean that better job satisfaction was indicated by higher scores. This made no difference to the validity of the original scale. For the purpose of this thesis the job satisfaction variable is treated as a continuous variable. Descriptive data from this variable are presented in Table 4.2 with the rating “terrible” scored as one and the rating “delighted” is scored as seven.

The proportion of respondents that reported they were delighted with their current job was 4.7 per cent. Respondents who were pleased comprised 15.9 per cent of responses. The highest proportion of responses came from the mostly satisfied category with 37.9 per cent. The middle response of Mixed (about equally satisfied and dissatisfied) had the second highest proportion of responses with 30.2 per cent. The equivalent proportions for mostly dissatisfied, unhappy and terrible were lower with proportions of 6.9 per cent, 3.9 per cent and 0.4 per cent respectively. In the first column of Table 4.3 some descriptive statistics are presented for the job satisfaction variable. It had a mean of 4.68 and standard deviation of 1.12. There were 17 missing values for this variable.

Figure 4.1 graphically represents the distribution of the job satisfaction variable. The x axis has the seven different responses available in the job satisfaction variable and the y axis displays the frequency that these occurred. As can be seen in Table 4.2 the high response to the mostly satisfied category is the main peak of the distribution curve. The data

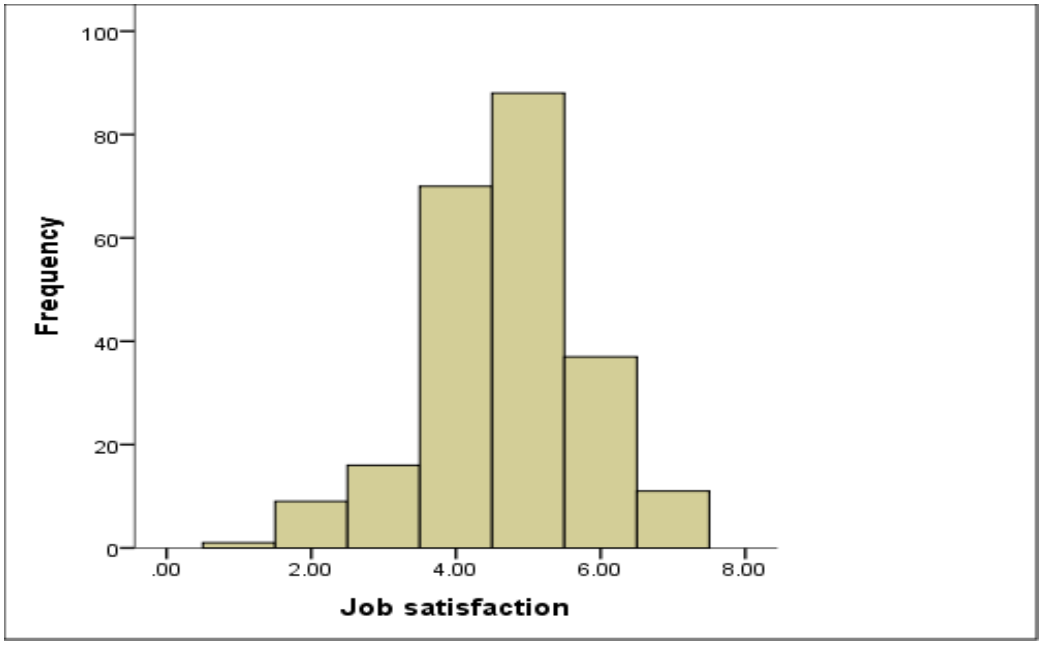
appears to have a slight negative skew, where the dissatisfied answers are displayed; however it has a broadly symmetrical shape with a single peak.

Table 4.2: Outcome measure: Job satisfaction descriptive values

	n	%
Delighted	11	4.7
Pleased	37	15.9
Mostly satisfied	88	37.9
Mixed (about equally satisfied and dissatisfied)	70	30.2
Mostly dissatisfied	16	6.9
Unhappy	9	3.9
Terrible	1	0.4
Total	232	100

Missing values=17

Figure 4.1: Job satisfaction histogram



Karasek domain variables

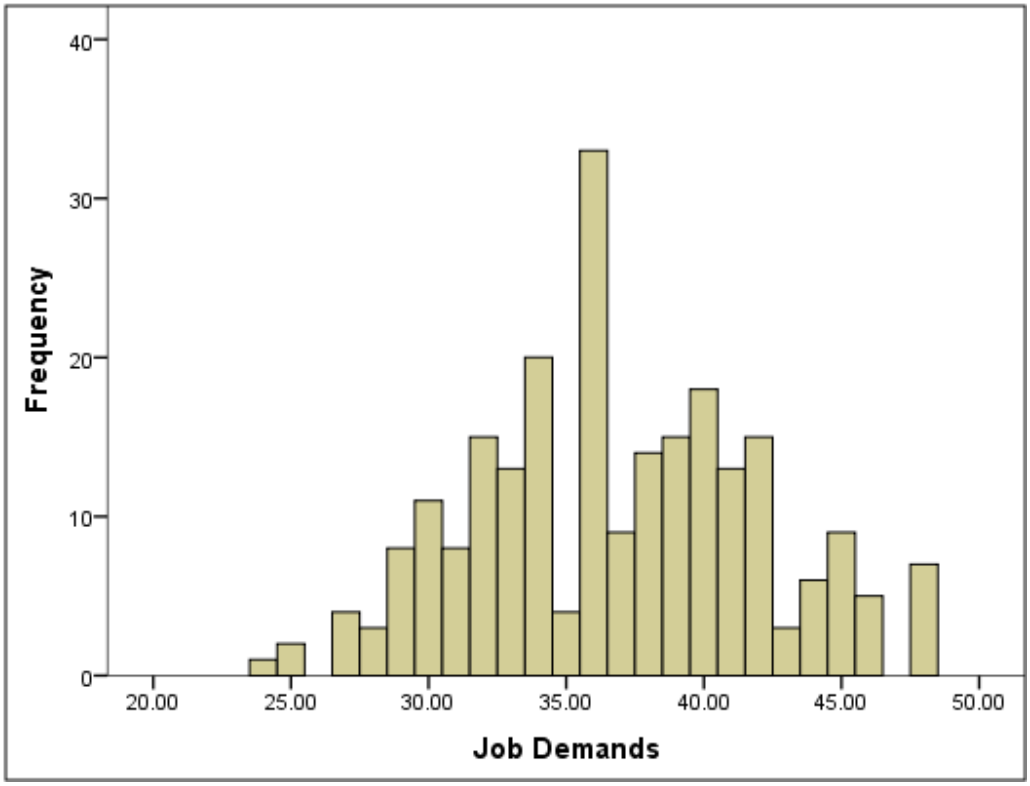
As noted previously in Chapter 3, the questionnaire asks a range of questions to determine the key psychological determinants of stress as devised by Karasek (1979). In addition to the job satisfaction outcome variable, the Karasek domains of job demands, job controls and social support are scales of interest when determining whether workplace wellbeing varies in different team types. These variables have been described in Box 4.1 at the end of this chapter. Summary statistics have been calculated and the results are detailed in Table 4.3. These summary statistics describe the means and standard deviations of the key variables as well as outlining the range and missing values. Histograms have also been plotted for the key Karasek variables and are presented and discussed below. Unfortunately no normative data are available for the UK, nor threshold values indicating significant sub-groups of respondents.

Job demands

The job demands variable consists of five-items measuring perceptions of the degree of work related pressures. The variable job demands was coded and computed from the raw data by the thesis author, based on scoring information from the original paper by Karasek (1979). Respondents from the whole dataset reported a mean of 36.82 for this variable with a standard deviation of 5.12. The minimum and maximum values of this variable in the dataset ranged from 24 to 48. There were 13 missing values in relation to this variable.

The histogram in Figure 4.2 graphically represents the distribution of the data for the job demands variable. The x axis displays the job demands variable, from lowest numbers through to the highest ones and the y axis is the frequency that these responses occurred. The data for this variable, although lacking some features of the standard normal distribution, does represent a symmetrical distribution with a central mean.

Figure 4.2: Job demands histogram



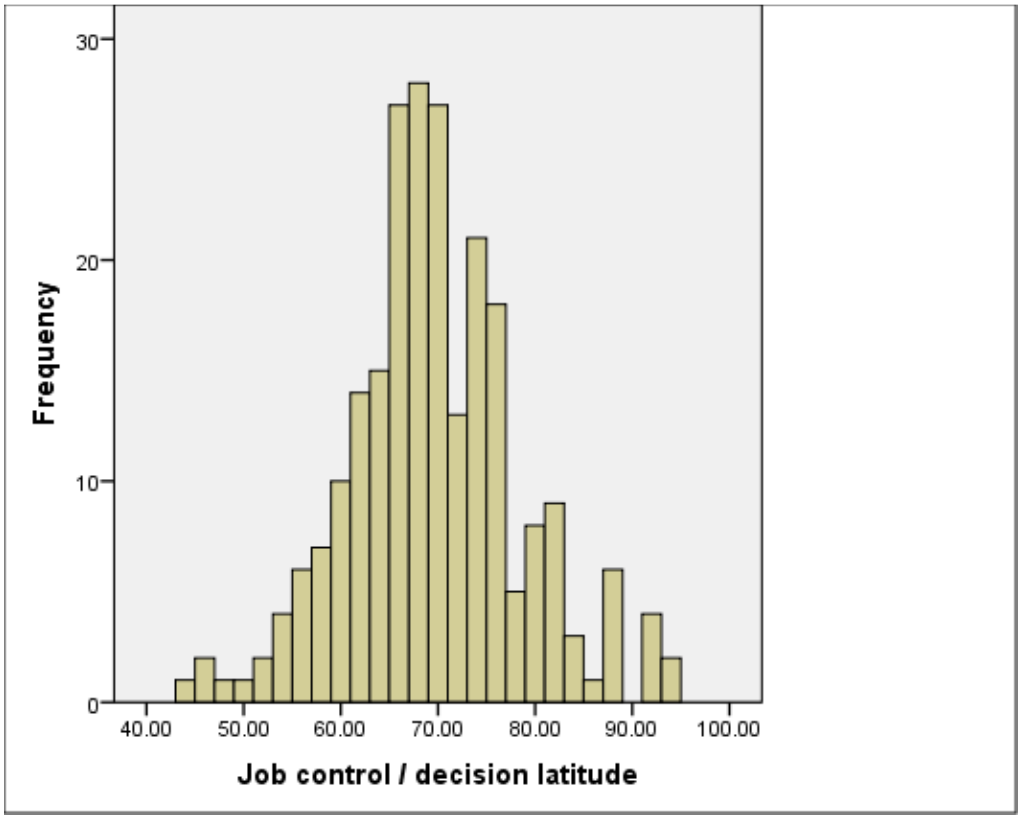
Job control (known formally as decision latitude)

For the purpose of the analyses in this chapter, job control is shown as a composite variable representing the simple sum of nine items from the two sub-scales from which it is derived (skill discretion and decision authority). The graphical representation of this in Figure 4.3 is the combined version. The author undertook the same procedure for coding these variables, using the raw data and basing the new variable on the guidance provided Karasek, (1979). The variable name of job control was used throughout this thesis to avoid over complication with the more formal name of decision latitude.

Table 4.3 shows the mean score for the sample was 69.59 and the standard deviation was 8.97. In this group of respondents the minimum and maximum scores achieved with this sample were 44 and 94. This higher range reflects the combination of the two variables that comprised the sub-scales. There were only 14 missing values.

The histogram in Figure 4.3 graphically represents the distribution of the spread of the data for this job control variable. The x axis displays the job control variable, from lowest values through to high values and the y axis shows the frequency that these responses occurred. The data for this variable does appear to be normally distributed with a classic bell curve effect. This histogram provides graphical representation of the range of the variable and the presence of equal sides to the curve from the mean clearly shows a normal distribution.

Figure 4.3: Decision latitude/job control histogram



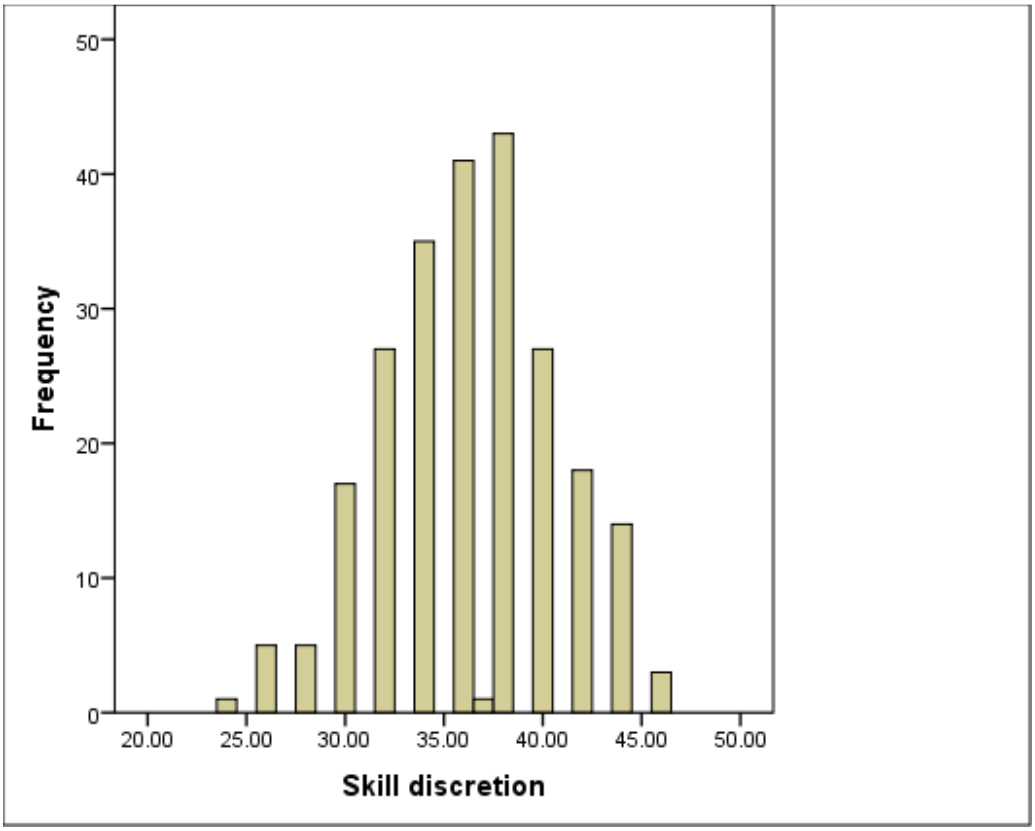
Skill discretion (sub-scale of the job control variable)

This variable was also computed from the raw data in the sample and comprised five items measuring the variety of skills that the respondents felt able to use and develop in the course of their job role. The mean value (not presented in Table 4.3), was 36.27 and the standard deviation from this

mean was 4.41. The minimum and maximum values for the ranges were 24 to 46 respectively. Missing values for this variable were again low (12).

The histogram in Figure 4.4 graphically represents the distribution of the spread of these data for this variable. The x axis displays the skill discretion variable, from lowest numbers through to the highest ones and the y axis shows the frequency of these responses. These data again appear to be normally distributed with the traditional bell curve, with the apex of the graph clustered around the mean and tapering equally on both sides.

Figure 4.4: Skill discretion histogram

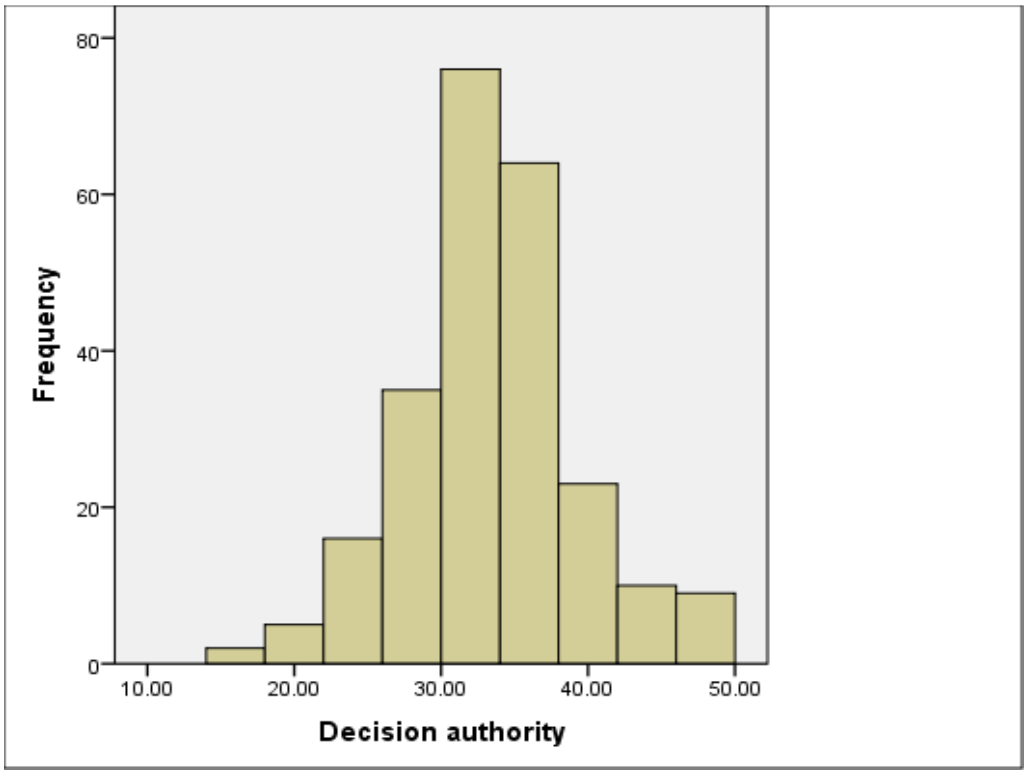


Decision authority (sub-scale of the job control variable)

This variable was computed from the raw data in the sample and comprised three items measuring the respondents' perceptions of the degree of control over key decisions affecting their work environment. The mean was 33.43 and the standard deviation was 5.99. The minimum and maximum values for the ranges were 16 and 48 respectively. Missing values were again low with only 9 values missing.

The histogram in Figure 4.5 graphically represents the distribution of the spread of the data for the decision authority variable. The x axis displays the range of the decision authority values from lowest numbers through to highest and the y axis shows the frequency of these responses. The data for this variable appears to have a slight skew, with responses gathering on the right of the graph. This skew was one underlying reason for the decision to combine the two sub-scales.

Figure 4.5: Decision authority histogram



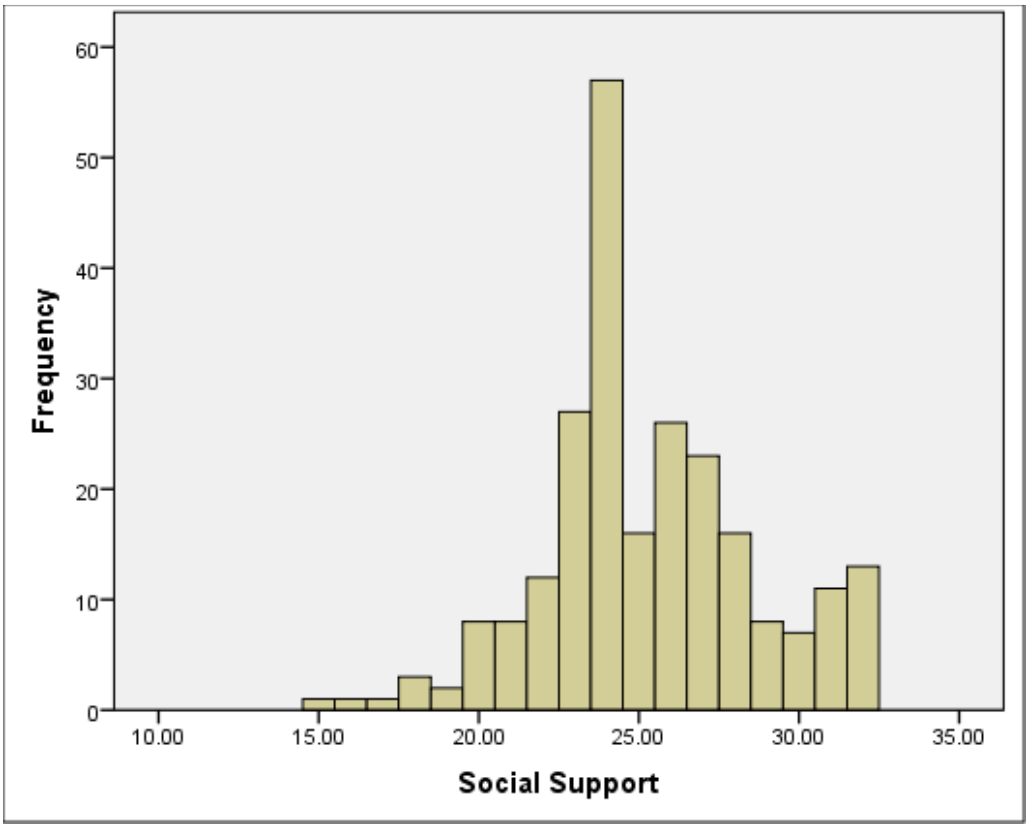
Social support

The social support variable consists of a weighted sum of the co-worker support and supervisory support variables. For the purpose of the analyses in this chapter, social support has been separated into its two constituent sub-scales as well as being a composite variable. It was felt that this would provide a truer reflection of the respondent's views on supervisory and co-worker support than a combined variable. The author undertook the same procedure for coding these variables as the Karasek variables outlined above. This involved using the raw data and creating new variable computations based on the guidance produced by the original author (Karasek, 1979).

The mean value for the combined social support variable was 25.27 and the standard deviation from this mean for the respondents was 3.33. The minimum and maximum values were 15 and 32 respectively. Missing values for this variable were again low (9).

The histogram in Figure 4.6 graphically represents the distribution of the spread of the data for this combined social support variable. The x axis displays the social support values, from the lowest numbers through to the highest ones and the y axis shows the frequency of these responses. The data for this variable does have a skew with higher numbers gathering on the right of the graph. The distribution shows a modal score of 24 reported by nearly one quarter of respondents. This corresponds to a score obtained by answering 'agree' to each question in the domain. This was a main reason that underlay the decision that this variable should be broken down into its component parts and analyses conducted on these instead. The two sub-scales are outlined in the next section.

Figure 4.6: Social support



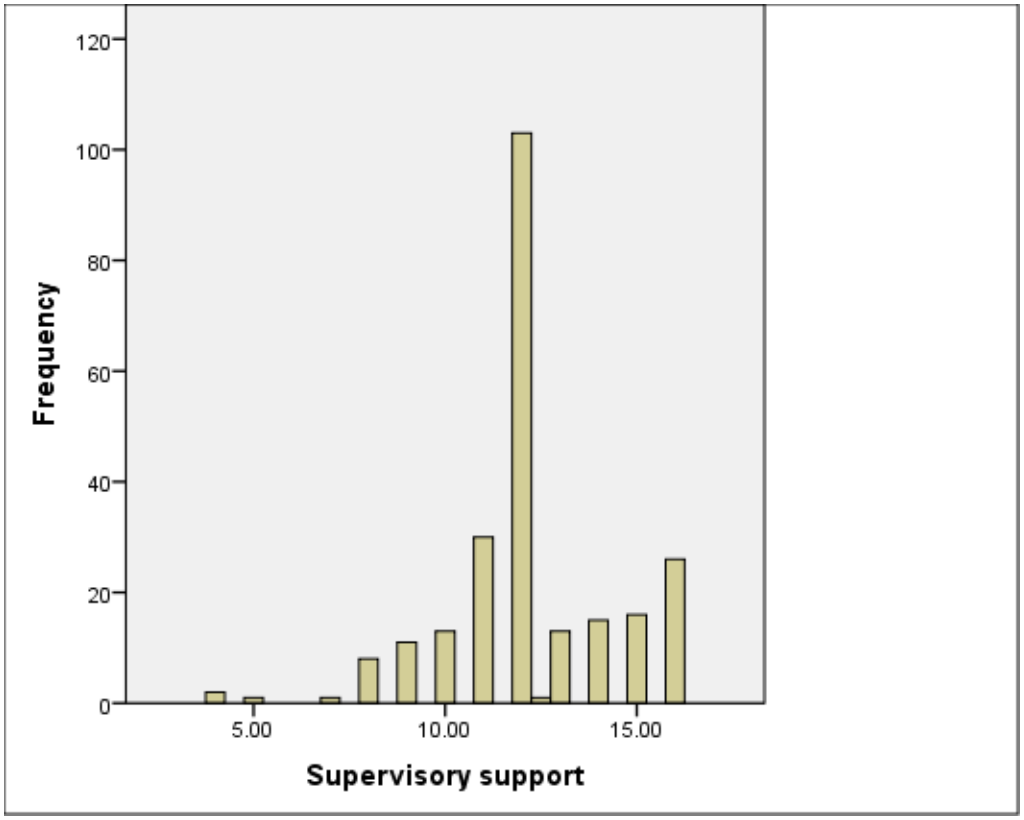
Supervisory support (sub-scale of the social support variable)

This variable was computed from the raw data in the sample and comprising five items measuring respondent satisfaction with support that respondents receive from their managers. The summary statistics for this variable are presented in Table 4.3. The value of the mean was 12.19 and the standard deviation from this mean was 2.18. The minimum and maximum values were 4 and 16 respectively. Only a few values were missing (6).

The histogram in Figure 4.7 graphically represents the distribution of the spread of the data for this supervisory support variable. The x axis displays the range of the supervisory support values from lowest numbers through to highest and the y axis shows the frequency of how often these responses occur. The data for this variable again has a negative skew with higher results gathering on the right of the graph. There is a main spike in the graph around the modal value of 12 and this has led to a unimodal distribution. The

data for this variable are suitable for use in the following analyses but it is worth noting that the spread of the data was not normally distributed. The spread of the data on this histogram may probably be explained by the nature of the questions and the experience of respondents.

Figure 4.7: Supervisory support histogram



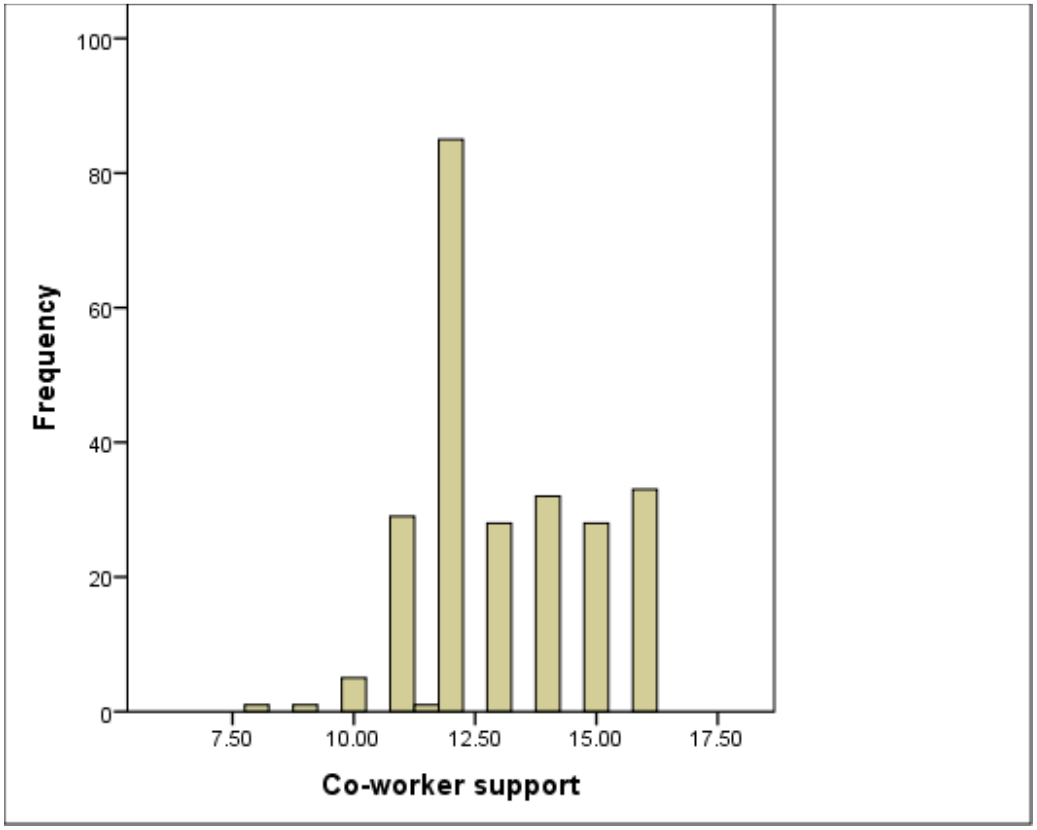
Co-worker support (sub-scale of the social support variable)

This variable was computed from the raw data in the sample and consisted of six items measuring perceptions (both instrumental and emotional) of support from work colleagues. The summary statistics for this variable are presented in Table 4.3. The value of the mean was 13.08 and the standard deviation from this mean was 1.74. The minimum and maximum values for the ranges were 8 to 16. Again, missing values were few (9).

The histogram in Figure 4.8 graphically represents the distribution of the spread of the data for this co-worker support variable. The x axis displays

the range of the co-worker support values from lowest numbers through to highest and the y axis shows the frequency of these responses. This variable has a negative skew with higher results gathering to the right of the graph. There is a main spike in the graph around the mean value of 13.08. The data for this variable are suitable for use in future analyses but as with the variable supervisory support the spread of the data is not entirely normally distributed.

Figure 4.8: Co-worker support histogram



Internal validity of the scales

Table 4.3 presents Cronbach's alpha scores calculated for the key Karasek variables to measure their internal consistency. The job satisfaction variable was not applicable as this is a single item scale and thus only had one question. The results of the Cronbach alpha computations all met the relevant standard thresholds for internal consistency (Streiner and Norman, 2008) for all of the sub-scales of the Karasek domains. Job demands (nine items) and Job controls (eight items) had the lowest levels, with alpha scores of 0.72 but these still met the thresholds. The supervisory support (five items) and co-worker support (six items) scales also scored highly with Cronbach alpha scores of 0.87 and 0.81 respectively.

Correlation coefficients

Correlation analyses were undertaken and these findings are presented in Table 4.3. For the job satisfaction variable the findings were as expected. As job demands decreased there was a significant increase in job satisfaction scores among the respondents (two-tailed Pearson correlation: $r=-0.260$, $p<0.001$). As expected, increased job control scores were significantly correlated with an increase in job satisfaction (two-tailed Pearson correlation: $r=0.423$, $p<0.001$). High scores in the supervisory support variable were significantly correlated with increased levels of job satisfaction (two-tailed Pearson correlation: $r=0.471$, $p<0.001$). Higher scores of co-worker support were also significantly correlated with increases in job satisfaction (two-tailed Pearson correlation: $r=0.275$, $p<0.001$).

The job demands variable score was not significantly associated with job controls, although there was a tendency towards negative correlation. The same was true of supervisory support. The reverse was true in relation to the co-worker support variable whereby an increased amount of co-worker support was weakly associated with increased job demands. However these correlations were not significant.

Higher levels of job control were associated with higher levels of supervisory support (two-tailed Pearson correlation: $r=0.375$, $p<0.001$). The same was true of the co-worker support, with higher co-worker support associated with greater levels of job control (two-tailed Pearson correlation: $r=0.358$, $p<0.001$). The supervisory support variable was also positively correlated with co-worker support, therefore higher co-worker support co-existed with higher supervisory support (two-tailed Pearson correlation: $r=0.437$, $p<0.001$). It is worth emphasising that the significant associations between these variables do not constitute causation. A number of additional factors and interactions between these variables will be explored later in this chapter.

Table 4.3: Job experience outcome measures: descriptive statistics and correlation coefficients

	Job satisfaction	Job demands	Job controls	Supervisory support	Co-worker support
Summary statistics					
Mean	4.68	36.82	69.59	12.19	13.08
Standard deviation	1.12	5.12	8.97	2.18	1.74
Min	1.00	24.00	44.00	4.00	8.00
Max	7.00	48.00	94.00	16.00	16.00
Missing values	17	13	14	6	9
Cronbach alpha	n/a	0.72	0.72	0.87	0.81
n	232	236	235	240	243
Correlation coefficients[†]					
Job demands	-0.260				
	(p<0.001)				
Job controls	0.423	-0.073			
	(p<0.001)	(0.273)			
Supervisory support	0.471	-0.055	0.375		
	(p<0.001)	(0.402)	(p<0.001)		
Co-worker support	0.275	0.028	0.358	0.437	-
	(p<0.001)	(0.672)	(p<0.001)	(p<0.001)	-

[†] Pearson correlation coefficients (p-values)

Table 4.4: Job experience outcomes and team-related characteristics

		Job satisfaction (Mean)	Job demands (Mean)	Job controls (Mean)	Supervisory support (Mean)	Co-worker support (Mean)
Age‡	<35	4.74	36.44	67.40	12.06	12.87
	35-44	4.78	36.64	70.38	12.38	13.34
	45-54	4.69	36.76	70.85	12.07	13.00
	55+	4.40	37.12	69.21	12.17	13.00
Gender	Male	4.59	37.73	69.18	11.97	13.09
	Female	4.73	36.51	69.68	12.27	13.08
Employment status	Full time	4.69	37.04	69.93	12.27	13.05
	Part-time	4.60	35.50	68.13	11.88	13.24
Service area†	Older people	4.76	36.77	68.68	12.73	13.11
	Physical disabilities	4.75	37.04	69.16	12.52	13.24
	Learning disabilities	4.54	37.08	69.72	11.80	12.98
	Mental health	4.80	36.66	70.34	12.10	13.15
Team type	Social care only	4.70	36.64	68.84	12.54	13.09
	Multi-agency team	4.67	36.86	70.94	11.66	13.03
Team size‡	<=10	4.90	35.99	71.12	12.51	13.24
	11-15	4.58	36.72	69.84	12.18	13.08
	16-20	4.53	38.62	68.30	12.21	12.89
	21+	4.54	36.54	67.73	11.56	12.94
Size of active caseload‡	<15	4.63	35.03	69.66	12.62	13.16
	15-24	4.72	37.09	69.58	11.68	12.88
	25-34	4.78	37.13	68.94	12.06	12.65
	35-44	4.73	39.27	71.20	13.00	13.97
	45+	4.50	38.33	68.83	13.25	13.92

† Not mutually exclusive categories. ‡These variables are classed as continuous for the purpose of the tests of association

Descriptive tables

Mean values for job satisfaction and personal and job characteristics across a range of personal and team related characteristics are presented in Table 4.4. Tests of association were also undertaken and are presented below. The following sections are organised by different variables to ease interpretation of the data.

Age

The dataset revealed that for the age variable there was little spread between the mean values in job satisfaction, job demands, supervisory support and co-worker support. The job control variable mean ranges from 67.4 in the under 35 age category to 69.2 in the older than 55 years category. Taking this age variable as continuous for analysis purposes, a Pearson's correlation was undertaken. However there were no significant associations between age and job satisfaction, and the Karasek job outcome variables.

Gender

There were few differences between the means for the two genders. Males reported a slightly higher level of job demands than females in this dataset. However after running a two-tailed t-test none of these differences between the means reached statistical significance thresholds.

Employment status

Working full or part-time showed no differences between the means except for the job demands variable. When respondents worked full time they reported higher levels of job demands than respondents who only worked part-time. This was found to be just outside conventional significance thresholds (two-tailed t-test: t=1.789, df=229, p=0.075).

Service area

With regard to the service area variables, respondents could work across multiple groups. The variables were treated as binary (yes, no) for the purpose of this table. It was not simple therefore, to interpret the means across the different service areas. The variable of key interest to the thesis was whether respondents worked with older people. Respondents working with older people reported significantly higher supervisory support than respondents that did not work with older people (two-tailed t-test: t=-3.991, df=238, p<0.001).

Team type

Another key variable that will be used throughout this chapter is the team type variable. Respondents were asked if they worked in multi-agency or social care only teams. There were no differences between means in these two groups in relation to job satisfaction. This is interesting as one of the key themes for this thesis is to discern whether there are any differences arising from working in these differing team types. There were also no differences between the means for the job demand or co-worker support variables by team type. For the job control variable however respondents reported slightly higher levels of job control in multi-agency teams (70.94) than respondents working in social care only teams (68.84). This finding was not significant but it did approach significance (t-tailed t-test: t, -1.747, df=228, p=0.082). Respondents working in multi-agency teams reported significantly lower levels of supervisory support than respondents working in social care only teams (two-tailed t-test: t=3.025, df=233, p=0.003).

Number of members in the team (size)

With regard to the team size variable, the mean scores showed that the fewer people in a team the higher the levels of satisfaction reported. As team size increased job satisfaction decreased and this was found to be statistically significant (two-tailed Pearson correlation: r=-0.157, p=0.022). Furthermore, in smaller teams there were lower job demands recorded on average, which is noteworthy as it might have been expected for the reverse to be true. However, overall, this did not reach significance. It appeared that

higher co-worker support was present in smaller sized teams, although this also failed to reach significance thresholds. Job control means were lower on average in larger teams but again this did not reach statistical significance. One finding that was significant was supervisory support which appeared to decrease as team size increased (two tailed Pearson correlation: r=-0.203, p=0.003).

Size of active caseload

Job satisfaction did not vary significantly with caseload size. Job controls also showed no difference in means between differing caseload sizes whilst mean job control appeared higher among respondents with caseload sizes of 35-44, but this was not significant. Supervisory support also appeared to increase as caseload size increased however again this did not reach significance. Co-worker support means varied with a decrease in middle caseload sizes and an increase with higher caseload sizes, but this was again not statistically significant. One association that did reach significance was the expected correlation between job demands and caseload size where unsurprisingly as the former increased then there were increases in the latter (two-tailed Pearson correlation: r=0.209, p=0.002).

4.4 Bivariate analysis - team type

As the main aim of this thesis is to explore differences and similarities between differing types of team composition the analyses in this section were undertaken considering time use as well as the Karasek indicators. Table 4.5 shows the survey respondents' characteristics, as described in the previous section, this time broken into multi-agency and social care only team types. In addition to these, tests of association (t-tests and chi-squared) are reported.

In Table 4.5 descriptive data showed that multi-agency and social care only teams were similar in terms of the age and gender of the respondents. Both teams had higher proportions of females (77.6% and 71%) and chi squared tests showed that there was no significant difference in relation to gender

between the teams. Both had similar mean ages of staff (43.05 and 44.27) with an age range in multi-agency teams of 23 – 64 years and social care only teams of 25-63 years. Age was treated as a continuous variable and a two-tailed independent t-test was undertaken which showed no significant differences in age between the two different team types. With regard to the proportion of staff working full time, the mean appears higher in multi-agency teams at 82.40 than social care only teams at 76.40, but no significant differences are apparent using chi squared tests. Respondents working in multi-agency teams appeared to have been in post longer than staff working in social care only teams (10.04 to 8.56 years respectively) but this finding was also not significant. The size of active caseload was another variable where the means were extremely similar, 22.20 for multi-agency teams and 22.52 for social care only teams and again the difference was not significant.

With regard to service area respondents to the questionnaire could report more than one category. This needs to be taken into consideration when interpreting these findings. Despite these multiple options there was a much higher proportion of respondents working with older people in social care only teams than in multi-agency teams, 71.80 per cent and 17.60 per cent respectively, (Chi-squared: X^2=66.50, p<0.001). This is particularly relevant as older people's teams are the service area of focus throughout this thesis. Furthermore, all the additional three service areas where respondents could have worked showed significant differences between them.

Respondents working in physical disability services were more likely to work in social care only teams than multi-agency teams. For learning disability and mental health service areas respondents were by contrast more likely to work in multi-agency rather than social care only teams. An additional finding was that, as expected, team size was significantly greater in multi-agency teams than the social care only teams (two tailed t-test, t=-4.42, df=110.52p <0.001).

Table 4.5: Sample characteristics by team type

	Social care team	Multi-agency team	t or x^2 value†	p-value
n	149	91	249	
Age (mean years)	43.05	44.27	t= -0.89	0.375
Gender (% female)	77.60	71.10	X^2= 1.24	0.282
% full time	76.40	82.40	X^2= 1.24	0.330
Service area* (% working with):				
Older people	71.80	17.60	X^2= 66.50	p<0.001
Physical disabilities	55.00	7.70	X^2= 54.27	p<0.001
Learning disabilities	25.50	50.50	X^2= 15.58	p<0.001
Mental health	20.80	44.00	X^2= 14.54	p<0.001
Length of time in post (mean years)	8.56	10.04	t= -1.25	0.214
Team size (mean)	13.61	20.83	t= -4.42	p<0.001
Size of active caseload (mean)	22.52	22.20	t= 0.14	0.886

†Values based on two-tailed t-test and χ^2-test. * Not mutually exclusive categories

Diary study variables

The time-use variables have been previously outlined in Chapter 3 (Box 3.3), and a brief summary of these can be found in Box 4.1 at the end of this chapter. These are: Direct contact with service user (9 tasks); Direct contact with carers (3 tasks); Contact with Services (fourteen tasks); Social Service Administration (8 tasks); Travel (4 tasks) and Approved Social Workers duties (ASW – 3 tasks). Combinations of these have been computed for some sections in this chapter, which will be outlined at the point in the text where this has occurred.

Table 4.6 shows the proportion of hours per week respondents undertook different types of job tasks. These data were taken from the diary study section of the IBSEN dataset (Glendinning et al., 2007) and the variables have been listed in Box 4.1. The difference between social care only teams and multi-agency teams is shown. With regard to the multi-agency teams, respondents spent a significantly higher proportion of time in direct contact with service users (18.86 % of all recorded time) than staff in social care only teams,14.87 per cent, (two-tailed t-test: t=-2.61, df=132.07, p=0.010). In contrast, staff in social care only teams spent a significantly longer amount of time in contact with services than multi-agency teams (two-tailed t-test: t=3.33, df=164.88, p=0.001).

The difference in proportion of hours in direct contact with carers is not significant, although it suggests respondents in social care only teams may spend a little longer with carers than respondents working in multi-agency teams (3.42% to 2.61%). Respondents reported that for social services administration tasks there is a greater proportion of time spent on these tasks in multi-agency teams (29.35%) as opposed to social care only teams (26.82%) but again this does not show any significant difference. Multi-agency team respondents spent longer travelling than respondents working in social care only teams, (10.30% to 6.88%), respectively and this finding is statistically significant (two-tailed t-test: t=-3.53, df=125.75, p<0.001). Respondents spent more time on approved social worker duties in multi-agency teams than social care only teams but the difference was not significant.

Table 4.6: Proportion (%) of the working week spent by care coordinators on different job tasks

	Social care team	Multi-agency team	t value†	p-value
Direct contact with service user	14.87	18.86	-2.61	0.010
Direct contact with carer	3.42	2.61	1.31	0.193
Contact with services	40.74	34.21	3.33	0.001
Social services administration	26.82	29.35	-1.18	0.240
Travel	6.88	10.30	-3.53	0.001
ASW duties	0.53	1.36	-1.59	0.114

†Values based on two-tailed independent t-test

Job satisfaction and Karasek variables

The differences between job satisfaction scores and Karasek variables for staff working in multi-agency and social care only teams can be found in Table 4.7. The job control variable is reflected in the two component sub-scales of skill discretion and decision authority. With respect to the job satisfaction scores the sample means are very similar and there are no significant differences between the team types.

For the Karasek variables job demands appear to have very similar scores and therefore no significant findings. Similarly, the skill discretion and co-worker support variables have almost identical means with no significant difference between the multi-agency and social care only teams. With regard to decision authority, respondents reported greater decision authority when they worked in multi-agency rather than single agency teams (two-tailed t-test: t=-1.99, df=233, p=0.048). Respondents that worked in social care only teams appeared to have more supervisory support than those in multi-agency teams (two-tailed t-test: t=3.14, df=233, p=0.002).

Table 4.7: Job satisfaction and Karasek domains versus multi-agency and single agency teams

	Social care only team	Multi-agency team	t value[†]	p-value
Job satisfaction	4.70	4.67	0.20	0.841
Karasek domains				
Job demands	36.64	36.86	-0.32	0.751
Skill discretion	36.10	36.61	-0.84	0.402
Decision authority	32.89	34.46	-1.99	0.048
Co-worker support	13.09	13.03	0.27	0.791
Supervisor support	12.54	11.66	3.14	0.002

[†]Values based on two-tailed independent t-tests

Table 4.8 presents correlations between respondents' job satisfaction scores, Karasek domains and job tasks (activities) in relation to team type. For this table the distinction between multi-agency and social care only teams has not been employed and the results are indicative of the full dataset. The contact with service users and contact with carer variables were merged for the purpose of analysis. The two activity variables of Travel and ASW duties were also excluded for this analysis as they were of peripheral relevance.

The main significant finding with regard to job satisfaction scores is that higher direct contact with both service users and carers was associated positively with a higher job satisfaction score (two-tailed Pearson correlation: r=0.166, p=0.013). Respondents who reported higher contact with services did not have an associated increase in job satisfaction. As expected higher levels of administration tasks were negatively correlated with job satisfaction, which meant that job satisfaction decreased as administration tasks increased. This association was on the borderline of the threshold of significance (two tailed Pearson correlation: r=-0.127, p=0.057).

With regard to the Karasek variables there were no significant associations with direct contact with service users and carers and the job demands, co-worker support and supervisory support variables. For the new variable of direct contact with both service users and carers there were two significant positive associations. This was for skill discretion (two-tailed Pearson correlation: r=-0.138, p=0.038) and decision authority (two-tailed Pearson correlation: r=-0.127, p=0.022).

For the direct contact with services tasks there were no significant associations to report. The association with increasing administration tasks and increasing job demands was close to an acceptable level of significance (two-tailed Pearson correlation: r=0.113, p=0.089). More administrative work was associated with less job satisfaction and increased job demands but these were also just outside the stated significance thresholds.

Table 4.8: Correlation between job satisfaction, job characteristics and job tasks

	Direct contact with service users and carers[†]	p-value	Contact with services[†]	p-value	Admin[†]	p-value
Job satisfaction	0.166	0.013	0.009	0.896	-0.127	0.057
Karasek Domains						
Job demands	-0.091	0.170	0.017	0.805	0.113	0.089
Skill discretion	0.138	0.038	-0.065	0.332	-0.094	0.156
Decision authority	0.151	0.022	-0.091	0.168	-0.022	0.739
Co-worker support	0.058	0.380	-0.042	0.518	0.031	0.641
Supervisor support	0.099	0.133	0.055	0.401	-0.076	0.248

[†]Values based on Pearson correlation coefficients- R value

4.5 Regression analyses

One of the key findings from section 4.4 was that respondents working in multi-agency teams appear to have significantly increased levels of decision authority but much less supervisory support than respondents working in social care only teams. These are both interesting to explore further. To what extent are these findings due to the supervisory support variable and how much of all of these results are due to working in a multi-agency team, and differences in characteristics of staff in those settings? This will be explored further using multiple regression analysis and logistic regression analyses, by modelling variables such as basic demographics, job characteristics and work activities that may have an impact on decision authority and supervisory support variables. New variables were constructed for use in the regression tables and a brief description of how these were constructed can be found in this section and in Box 4.1 at the end of the chapter.

New variables

Age was initially included in the regression models as a continuous variable, but this was not found to be significant. Further models were run to check for non-linear differences, with this variable being broken down into different quintiles and quartiles. Finally, a binary variable identifying younger workers (defined as aged under 36) was created. This was taken from the lowest quartile of the age distribution of respondents and was used in the analyses below.

Two further variables were used in these analyses and to create another variable. The first variable was the total number of contracted hours, which is what respondents reported that they were contractually obliged to work in a week. The second was the total number of actual hours worked. This was taken from the time-use activity study data by summing the total number of recorded hours. A ratio (centred on 100, meaning hours worked equalled contracted hours) was then constructed between the two, showing the hours

worked against contractual works. This is a proxy-measure for working long/short hours (reflecting that part-time workers can work long hours relative to their contract) and had a total of 223 cases with 26 missing values. The ratio had a mean of 102.9, suggesting that respondents overworked on average 2.9 per cent more hours over their contractually obliged hours (standard deviation of 18.0).

Various forms of the variable were considered so as to allow for linear and non-linear effects. The variable used in the model entitled 'works fewer hours relative to contracted hours' consisted of the lowest quintile of the contracted hours variable. This was the first fifth in the hours worked relative to the contracted hours worked that respondents may have answered with. It was used as a binary indicator for the logistic regression. If respondents worked fewer hours (first quintile) this was answered as yes (1) and if they answered with any other value then this was a no (0).

Job control was analysed using least squares analysis. Attempts to apply the same approach to supervisory support were not successful. This was probably due to the shape of the distribution (see above). The models which were fitted performed poorly and breached the assumptions of normality of residuals. The data was therefore recoded to create a high supervisory support variable. This was defined as those respondents that scored above the top quartile of supervisory support score which was (14+). This was used in the logistic regression to explore what variables impact on this.

Job control: ordinary least squares linear regression

Ordinary least squares regression indicated the contribution of individual predictor variables on a chosen outcome variable of interest. The variable of interest is decision authority and the model controls for other factors and variables so that the impact of each can be investigated. The main issue of interest in this thesis is the differential effect of working in multi-agency and social care only teams on decision authority.

Table 4.9 shows that respondents working in multi-agency teams had a higher level of decision authority than those in single-agency teams only (coeff=1.730). This effect, whilst not significant, is approaching the significance threshold (p=0.071). As the team type variable is a key variable of interest this has been left in the model and has been reported.

The model also indicates that respondents with a nurse/allied health professional qualification are likely to have a higher level of decision authority than those coming from a different professional background. The coeff=2.957 score shows that decision authority is expected to increase by nearly three when respondents have a nurse/allied health care professional background in contrast to those that do not. This was a significant effect (p=0.006).

It also appeared that younger workers were likely to have a lower level of decision authority than other age groups. The coeff=-1.798 shows this negative effect that decision authority will be almost two points lower for younger workers in the team. This just reached the significance threshold at p=0.050.

With regard to hours worked, the indicator of staff working a higher ratio of hours was associated with lower levels of decision authority but a much smaller amount of variation can be seen from the coeff=-0.039. This finding was approaching the significance threshold and so has been included in the model (p=0.079).

There are two additional variables in Table 4.9. Having professional qualifications and working with older people were both not significant. These effects have been included in the model. Despite the non-significant effects, their exclusion from the model led to a substantial fall in the variance explained, suggesting their joint inclusion was appropriate.

Table 4.9: Determinants of decision authority

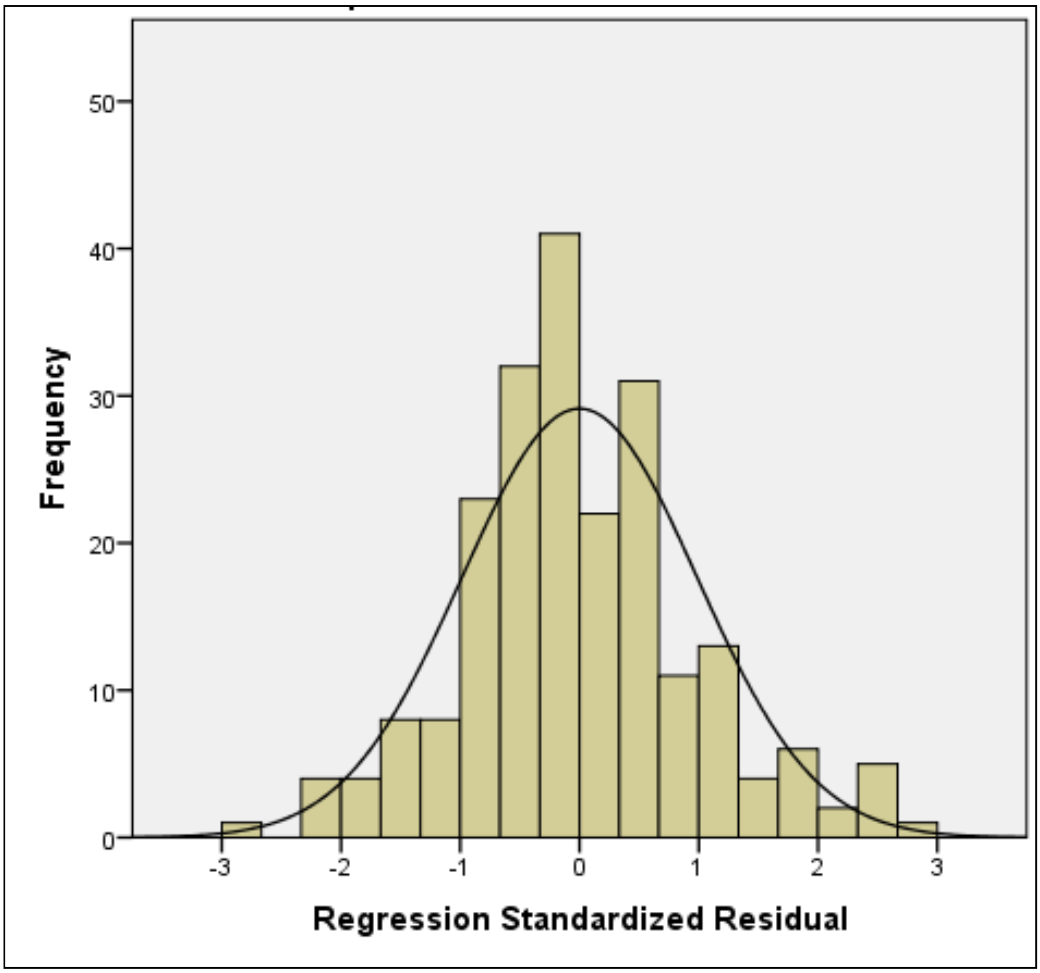
	Coeff.	S.E.	p-value
Member of a multi-agency team	1.730	0.934	0.071
Younger worker in team (bottom quartile)	-1.798	0.913	0.050
Has a nurse/allied health professional qualification	2.957	1.057	0.006
Ratio of hours to percentage worked	-0.039	0.022	0.079
No professional qualification	0.225	0.932	0.810
Working with older people	0.246	0.905	0.786
(Constant)	34.95	2.780	p<0.001

n=216; R^2=0.094; Adj R^2=0.068; F(6,209)=3.61

OLS regression diagnostics

Figure 4.9 shows the distribution of the standard errors, and these are centred on zero. This suggests that the standard errors have most of the characteristics of normal distribution (as many are above as below the centre, tailing off towards the end in both directions). Other diagnostic tests found there were few outliers skewing the data and that they lay within a normal distribution of the data. The model above appears to be normally distributed. An R^2 value of 0.094 and an adjusted value of 0.068 suggests that job control can be explained predominantly by other, unobserved factors. Nevertheless, the interpretations of the coefficients included in the model are reliable.

Figure 4.9: Standard errors in the model



Logistic regression

Table 4.10 shows a logistic regression model investigating differing team characteristic variables and their relationship to the probability of receiving high quality supervisory support. This was a key variable of interest from earlier findings in this chapter and the high supervisory support variable has been used as the dependant variable to investigate in this model. Many differing combinations of variables were considered in the analysis. Only the following were used in this final model as this was the best fit model to accurately report in this chapter. The odds ratio value (OR) has been reported as it provided a measure of the relationship between the explanatory variables and the probability of receiving high quality supervisory

support, holding other factors constant. Any value greater than one indicates a positive effect and any value less than one indicates a negative effect.

Respondents that worked in multi-agency teams were less likely to report high supervisory support than staff who worked in social care only teams. The odds ratio for this team type on high supervisory support was OR=0.247, and was statistically significant with p=0.020.

Another key variable of interest was whether or not respondents worked with older people. The results indicate that respondents who worked with older people were markedly more likely to report high supervisory support and this was statistically significant (OR=2.680, p=0.028).

Respondents who worked fewer hours were more than twice as likely to report high supervisory support and this finding was statistically significant (OR=2.305, p=0.038). Non-significant effects were whether respondents had a professional background of a nurse/allied health professional or if respondents had no professional qualifications.

Table 4.10: Logistical regression: High supervisory support

	Odds ratio	S.E.	p-value
Member of a multi-agency team	0.247	0.149	0.020
Works fewer hours relative to contracted hours (lowest quintile)	2.305	0.927	0.038
Team size	0.955	0.026	0.092
Working with older people	2.680	1.204	0.028
Has a nurse/allied health professional qualification	1.560	0.798	0.385
No professional qualification	1.644	0.705	0.246
(Constant)	1.058	0.983	0.951

n=199; pseudo R^2=0.176

The R^2 values are hard to estimate for logistic models, although estimates are provided in SPSS output for this. These include tabulation of predicted versus actual results and measures of the predictive accuracy of the model. When comparing actual versus predicted values for high supervisory support the model above correctly assigns 78.4 per cent of observations. This is compared against 50 per cent by chance, suggesting a reasonable model. One proviso is that the model appears to under classify high supervisory support respondents. Another cautionary note concerns the inclusion of working hours as an explanatory variable. It may well be that causal processes are reversed, so that poor supervisory support contributes to longer hours worked.

4.6 Summary

This chapter has described the IBSEN dataset and the analyses that have been undertaken on the variables in this. It details both the questionnaire and the diary study variables. Data management details have been outlined and any changes noted. Descriptive analyses noted that respondents in multi-agency teams had more contact with service users (increased scores of job satisfaction) and less contact with other services. Respondents also reported greater job control but poorer supervision scores in multi-agency teams. A logistic regression model showed that multi-agency working was still linked to poorer supervision and increased job control, even when controlling for other factors. The next chapter (Chapter 5) will present findings from the CMHTsOP dataset and these will be discussed.

Box 4.1: A list of variables in Chapter 4

Variable	How it has been used
Age	Continuous variable originally then recoded into the following categories: <35 (less than thirty five); 35-44; 45-54 and 55+ (fifty five and over).
Gender	Binary categorical variable – no further recoding.
Professional social work qualification	Binary yes/no variable – no further recoding.
Other professional qualification	Binary yes/no variable and an open ended box to record qualification. The thesis author computed variables from this list. • Nurse qualification – yes/no binary • Allied health care professional qualification – yes/no binary • No professional qualification – yes/no binary • Nurse and allied health care professional qualification – yes/no binary variable.
Working full or part-time	Binary yes/no variable – no further recoding.
Older people	Binary yes/no variable - no further recoding.
Physical disabilities	Binary yes/no variable - no further recoding.
Learning disabilities	Binary yes/no variable - no further recoding.
Mental health	Binary yes/no variable - no further recoding.
Team type	Multi-agency or social care only teams. Binary variable – no further recoding.
Team size	Continuous variable originally then recoded into the following categories: <=10 (less than or equal to ten); 11-15; 16-20 and 21+ (twenty one and over)
Job satisfaction	This is treated as a continuous variable. The original was scored with the following values: 1=Delighted; 2=Pleased; 3=Mostly satisfied; 4=Mixed (about equally satisfied and dissatisfied); 5=Mostly dissatisfied; 6=Unhappy and 7=Terrible. This was then reverse scored so that Delighted=7 through to Terrible=1.
Job demands	This is a nine item scale, with a range of possible scores from 38 to 54. For the purpose of this analysis this variable was computed from raw individual items and treated as a continuous variable.
Skill discretion	This is a six item scale, with a range of possible scores from 18 to 42. For the purpose of this analysis this variable was computed from raw individual items and treated as a continuous variable.
Decision authority	This is a three item scale, with a range of possible scores from 24 to 36. For the purpose of this analysis this variable was computed from raw individual items and treated as a continuous variable.
Job control (decision latitude)	This is a weighted sum of skill discretion and decision authority, with nine items with a range of possible scores from 42 to 78. For the purpose of this analysis this variable was computed from raw individual items and treated as a continuous variable.
Co-worker support	This is a four item scale, with a range of possible scores from 4 to 16. For the purpose of this analysis this variable was computed from raw individual items and treated as a continuous variable.
Supervisory support	This is a four item scale, with a range of possible scores from 4 to 16. For the purpose of this analysis this variable was

	computed from raw individual items and treated as a continuous variable.
Social support	This is a weighted sum of co-worker and supervisory support, with eight items with a range of possible scores from 8 to 32. For the purpose of this analysis this variable was computed from raw individual items and treated as a continuous variable.
Direct contact of services user	Nine tasks were listed and this variable was treated as a continuous variable.
Direct contact with carers	Three tasks were listed and this variable was treated as a continuous variable.
Contact with Services	Fourteen tasks were listed and this variable was treated as a continuous variable.
Social services administration	Eight tasks were listed and this variable was treated as a continuous variable.
Travel	Four tasks were listed and this variable was treated as a continuous variable.
Approved Social Worker duties	Three tasks were listed and this variable was treated as a continuous variable.
Regression 5 – variables included in the models	
Age	Continuous variable then recoded into Quartiles to make 'Younger worker in team' which is less than 36 years old.
Contracted hours	Binary from raw data
Actual hours	Binary from raw data
Ratio of hours	Computed variable - see text
Team type	Multi-agency or social care only teams. Binary variable – no further recoding.
Has a nurse/allied health professionals qualification	Binary from the raw data
No professional qualification	Binary from the raw data
Working with older people	Binary from the raw data
Regression 6 – in addition to some of the above these were included	
Team type	Multi-agency or social care only teams. Binary variable – no further recoding.
Works fewer hours	Worked fewer hours relative to contracted hours (in the last quintile of this category)
Team Size	See above
Working with older people	See above
Has a nurse/allied health professionals qualification	See above
No qualification	See above

CHAPTER 5: COMMUNITY MENTAL HEALTH TEAM STAFF QUESTIONNAIRE AND QUALITATIVE INTERVIEWS

5.1 Introduction

This chapter explores the dataset from a postal questionnaire distributed to staff working in Community Mental Health Teams for Older People (CMHTsOP) across nine NHS Trusts in England. This dataset was part of a study as outlined in Chapter 3, and the author was involved in data collection for this work. In addition to the questionnaire a sub-section of respondents were invited to participate in interviews. The chapter consists of four sections. Firstly, simple descriptive results are displayed and discussed. These include personal and team-related characteristics of respondents in the data. The key variables of interest are job satisfaction and key job outcomes which are also described. Tables outline personal and team-related characteristics in relation to job satisfaction and Karasek variables, with graphical representations of the spread and tests of association undertaken. In addition to these tables a visual representation of the balance between job demands and job control - a job demand and job control diagram of individual staff group variations - is plotted and discussed.

Secondly, bivariate analyses are undertaken and considered using the key variable of integration level of the respondents' team settings. This variable is examined in relation to a range of personal and team related characteristics and key job outcomes. For both these analyses tests of association are undertaken and any significant differences commented upon. Thirdly, regression analyses are detailed, specifically investigating the Karasek hypothesis of job control acting as a mediator upon job pressure and the effects of other factors are also considered (See Chapter 3).

The fourth and final section comprises qualitative analyses conducted using data from interviews with staff. This section describes these findings in relation to the key areas of job outcomes (job demands, control, support, job satisfaction) team integration level and professional role.

5.2 Description of sample and key variables

All newly derived variables used for analyses are outlined in each section and a summary can be found in Box 5.2 at the end of this chapter. Any computations and recodes are explained and the analysis steps will be described so that these results can be replicated.

As described in Chapter 3 an initial screening telephone call was made to each team manager of the CMHTsOP involved in this study to gain initial information about the teams and the number of members in each. Questionnaires were sent to an estimated 500 staff members in CMHTsOP across 38 teams in nine NHS Mental Health Trusts in England. These were given out either directly during visits to teams, or indirectly via mail, and therefore the exact number of staff approached was difficult to specify. Questionnaires were returned by 295 respondents, which gave an estimated response rate of 59 per cent. Estimated response rates varied across the 38 teams with a range from 40 to 100 per cent. Data entry of these questionnaires and all data cleaning was undertaken by the author. Another member of the research team completed a 10 per cent check of all data entry to ensure validity. All analyses were undertaken by the author, with all assistance noted. A copy of the original questionnaire can be found in Appendix 2.

Personal and team related variables

Table 5.1 outlines the key personal and team-related characteristics of the respondents in this dataset from the sample as a whole. The following section has been divided into information about individual variables for ease of interpretation of the results. Any salient findings are outlined and key variations are noted.

Age

Respondents were asked to identify their age using five different categories. For this chapter the lowest two categories of 18-24 and 25-34 were collapsed

into one category (< 35) as they had low numbers. The largest proportion of responses were in the category 45-54 with 44 per cent and the next highest was the 35-44 category with 27.3 per cent. There were 16 per cent of responses in the older than 55 years category and the younger than 35 category only had 12.6 per cent of respondents. There were two missing values for this variable.

Gender

Approximately four fifths of staff were female (78.3%). There were no missing values for this variable.

Professional group

Respondents were asked what their role was within the CMHTsOP. Nurses comprised the largest professional group category within the sample with 40 per cent. Support workers were the next largest with 14.6 per cent. Other disciplines included psychologists and physiotherapists jointly comprising 10.8 per cent of the sample. Team managers and doctors were similarly represented (9.2% each). Occupational therapists comprised the second smallest (8.5%) and social workers the smallest group of respondents with 7.8 per cent. There were no missing values for this variable.

Employment status

Respondents were asked if they worked full, part-time or a part-time job share. For this chapter the last two categories were combined to form a binary variable of full time versus part-time working. Three quarters of respondents recorded that they worked full time (75.2%). There were seven missing values for this variable.

Active caseload size

Respondents were asked the size of their caseloads and recorded this as a continuous variable. In the original raw data the distribution of the data showed a small number of outliers. These outliers were checked, for any above 200, and all these were on doctor's caseloads. As it is expected that consultant psychiatrists and doctors have much higher caseloads than the

other professions that were retained for this section. However, one outlier with 435 cases was removed as a team manager had incorrectly completed this for the whole team caseload. The mean caseload size for the sample as a whole was 28.3. By professional group, doctors had the highest mean caseload size of 128; nurses had a mean caseload size of 36; social workers and 'other' had mean caseloads of 27 and 28 respectively; team managers and occupational therapists had mean caseloads of 22 and 23. As expected support workers had the smallest mean caseload size of 17, as they often did not actually hold a formal caseload *per se*.

The active caseload variable was later recoded into five different categories as can be seen in Table 5.1. The highest proportion was a caseload size of 15-24 cases with 27.9 per cent of responses and the lowest proportion caseload size fell into the category of 35-44 with only 14.7 per cent. There were 23 missing values for this variable.

Years employed in team

Respondents were asked how many years they had worked in the CMHTsOP and this variable was originally continuous. For the purpose of Table 5.1 it was recoded into four categories. The largest proportion of respondents had worked in the team for 2 to 5 years (38.5%). The second highest category was 10 years or longer with 26 per cent of responses. There were 30 missing values for this variable.

Team size

The team size variable was calculated from the number of members in each team, which was collected in the telephone interview with the team manager, prior to data collection. This continuous variable was then re-coded into categories for Table 5.1. Approximately two thirds of respondents (68.9%) worked in moderately sized teams with between 11 and 20 members. There were 19.3 per cent of respondents working in teams of ten or more and a much smaller proportion of respondents working in teams of ten or less (13.9 %).

As this variable was computed from data collected via a telephone interview there were no missing values.

Integration category

From the telephone interviews conducted by the author with team managers, information relating to the nine indicators of integration were recorded. These are outlined in Chapter 3, Box 3.4. An integration score of 1 to 9 was then re-coded into the following categories: low (1-3), medium (4-6) and high (7-9). The main proportion of respondents reported they worked in medium integration teams, (60.3%). Respondents working in low integration teams made up 22.4 per cent of the sample and fewer than a fifth of respondents (17.3%) worked in high integration teams.

As this variable was again computed from data collected via a telephone interview there were no missing values.

Missing values

The missing values in Table 5.1 all fell within the acceptable ranges for missing values. The data can be generalised from these variables and the thesis author sought guidance from a statistician as to whether there was a need to impute any variables. However, it appeared that the dataset seemed representative.

Data analyses training

In addition to advice from a statistician the author undertook several training days in statistical research methods. The process of working through training examples improved the author's statistical knowledge over the course of this thesis.

Table 5.1: Respondents personal and team-related characteristics

		n	%
Age	< 35	37	12.6
	35 – 44	80	27.3
	45-54	129	44.0
	55 +	47	16.0
	Missing	2	
Gender	Male	64	21.7
	Female	231	78.3
	Missing	0	
Professional group	Doctor*	27	9.2
	Nurse	118	40.0
	Occupational therapist	25	8.5
	Social worker	23	7.8
	Support worker	43	14.6
	Team Manager	27	9.2
	Other disciplines†	32	10.8
	Missing	0	
Employment status	Full time	218	75.2
	Part-time	72	24.8
	Missing	5	
Active caseload size	<15	53	19.5
	15-24	76	27.9
	25-34	57	21.0
	35-44	40	14.7
	45+	46	16.9
	Missing	23	
Years employed in team	< 2 years	49	18.5
	2 – 5 years	102	38.5
	6 – 9 years	45	17.0
	10 years +	69	26.0
	Missing	30	
Team size	<=10	41	13.9
	11-15	112	38.0
	16-20	85	28.8
	21+	57	19.3
	Missing	0	
Integration category‡	Low	66	22.4
	Medium	178	60.3
	High	51	17.3
	Missing	0	

†Predominantly psychologists and physiotherapists. ‡Categorisation of integration score: Low (1-3); Medium (4-6); High (7-9). *Consultant psychiatrists and other doctors

5.3 Outcome variables

Job satisfaction outcome variable

The job satisfaction variable is derived from a single question asking respondents to rate how they feel about their current job on a six item Likert scale. These six answers range from extremely dissatisfied to extremely satisfied, and more details are shown in Box 5.2. In the original raw dataset the variable scoring indicated higher scores for lower satisfaction levels and it was felt this would be confusing for the interpretation of data with the direction of effect for this variable being inverted compared with other variables. The scale was reversed so that that higher job satisfaction scores indicated higher levels of satisfaction. This reverse scoring had no impact on the validity of the original scale. For the purpose of this chapter job satisfaction will be treated as a continuous variable, in common with its usage by other authors (Evans et al, 2006).

Descriptive data from this variable are presented in Table 5.2, where 'extremely dissatisfied' is scored as one and 'extremely satisfied' is scored as six. This table shows that 72.6 per cent of respondents reported that they were either 'quite', 'very' or 'extremely' satisfied with their job. The highest proportion of respondents that answered were in the 'quite satisfied' category with 41.7 per cent. Overall 'extremely satisfied' and 'extremely dissatisfied' had the lowest proportions of responses, with 5.6 and 1.7 per cent respectively.

Table 5.3 displays the mean scores for respondents across the sample as a whole, 3.98 on the job satisfaction scale. The job satisfaction outcome measure was completed well and only had seven missing values. Figure 5.1 graphically represents the distribution of the job satisfaction variable. The x axis shows the scoring from one to six and the y axis records the frequency of these answers. It can be seen clearly from this that 'quite satisfied' (scored 4) has the highest peak since the highest proportion of respondents recorded this. The data appears to have a slight negative skew and

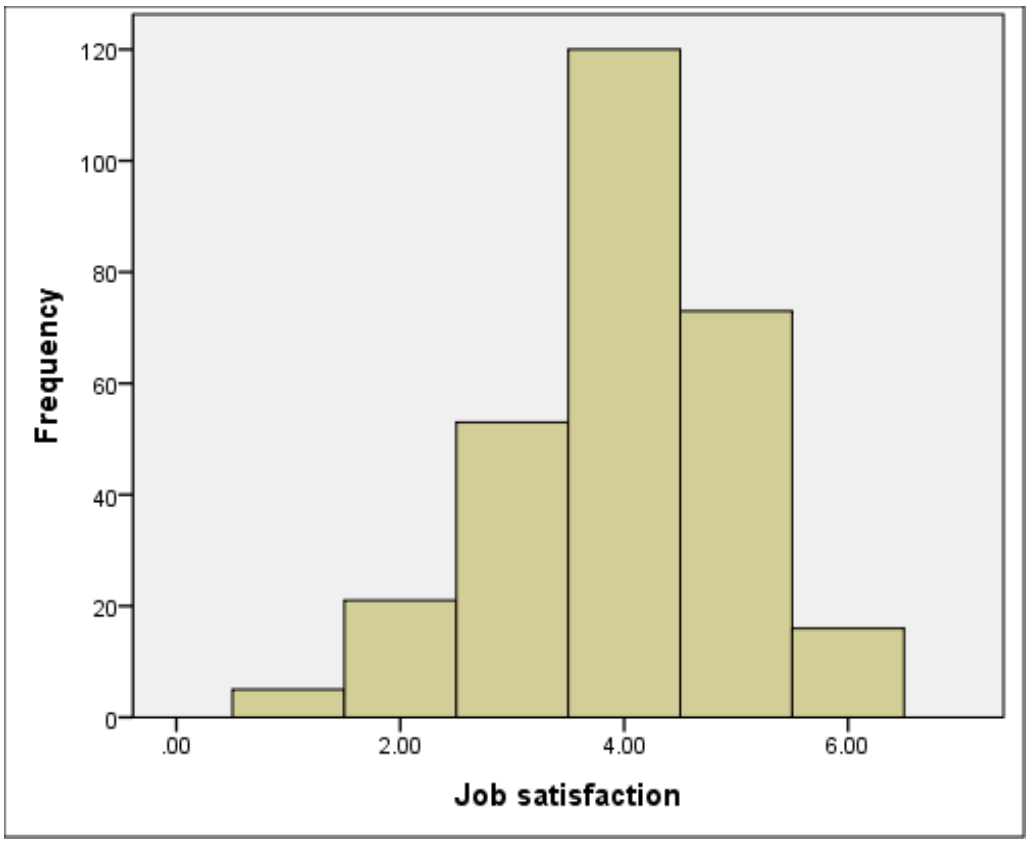
generally positive satisfaction scores, however overall the data in this distribution appear to be normally distributed.

Table 5.2: Outcome measure: Job satisfaction descriptive values

	n	%
Extremely satisfied	16	5.6
Very satisfied	73	25.3
Quite satisfied	120	41.7
Quite dissatisfied	53	18.4
Very dissatisfied	21	7.3
Extremely dissatisfied	5	1.7
Total	288	100

Missing values=7

Figure 5.1: Job satisfaction histogram

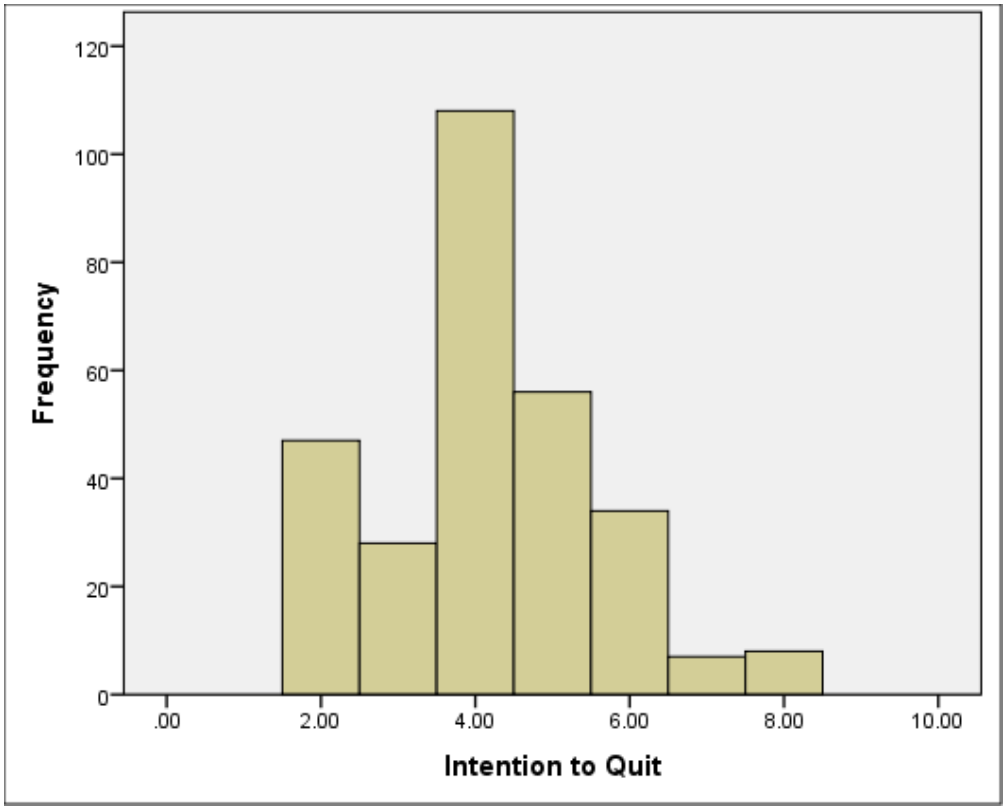


Intent-to-quit variable

This is a new outcome variable relevant in this dataset only. The intent-to-quit variable comprised two items and further details of this can be found in Chapter 3. The scoring of this variable is between 2 and 8 with lower numbers indicating less intent-to-quit and higher numbers indicating more intent-to-quit. Similar to job satisfaction it could be used as a categorical variable, however, as for other Likert style responses, for the purpose of this work it has been treated as a continuous variable.

As can be seen in Figure 5.2, just over a third (35.4%) of respondents agreed or strongly agreed that they often thought about quitting their job. Table 5.3 shows that 4.19 is the average with a standard deviation of 1.43 for this variable. There were 7 missing values. The intent-to-quit variable is used as an outcome variable in later tables.

Figure 5.2: Intent-to-quit histogram



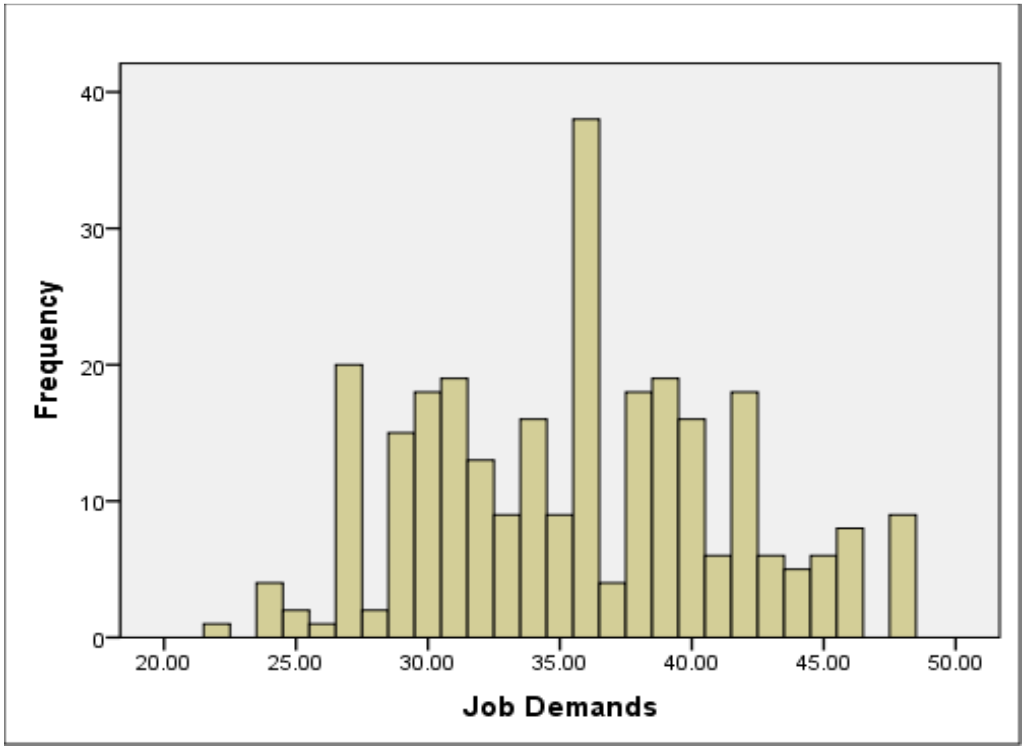
Karasek domain variables

As noted in previous chapters of this thesis, a battery of questions was asked of respondents to determine key psychological determinants of stress (Karasek, 1979). It is of interest to explore these domains. Summary statistics were calculated and these can be seen in Table 5.3. These describe means of the key variables, standard deviations from these means and the minimum and maximum range of the data. Missing values were also noted and will be discussed.

Job demands

Respondents as a whole reported a mean score of 35.66 for the job demands variable, with a standard deviation of 5.83. The minimum and maximum scores for this variable were 22 and 48. Missing values were low with only 14 values. The histogram in Figure 5.3 shows the distribution of the scores for this variable.

Figure 5.3: Job demands histogram

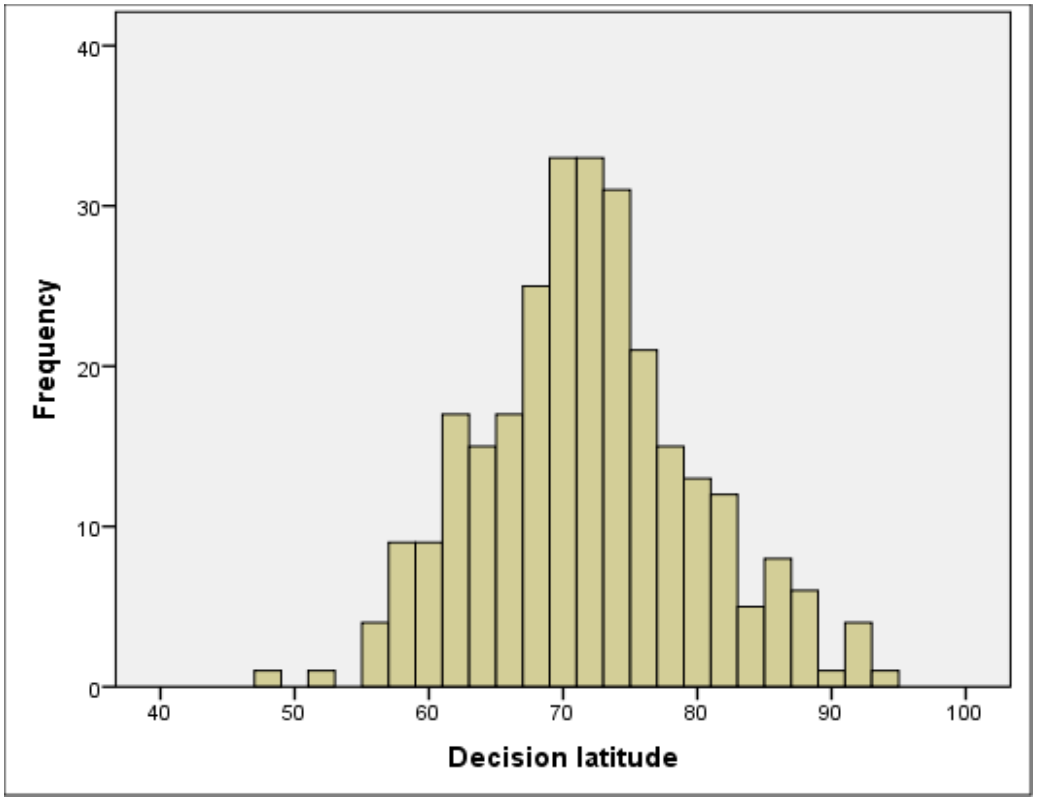


Job control (known formally as decision latitude)

For this section the variable of job control is shown as a combined version of the two sub-scales of skill discretion and decision authority. The two sub-scales are discussed below to provide a description of the dataset as a whole. In later sections of the chapter, only the combined variable of job control will be used. The job control variable comprises nine items. Table 5.3 shows it has a mean score of 71.81 with standard deviation from this mean of 8.04. The minimum and maximum values for it were 48 and 94 with 14 missing values.

The histogram, shown in Figure 5.4, shows a reasonable approximation to a normal distribution for the job control variable. The spread around the mean is a standard bell curve with similar proportions of responses on each side of the mean peak.

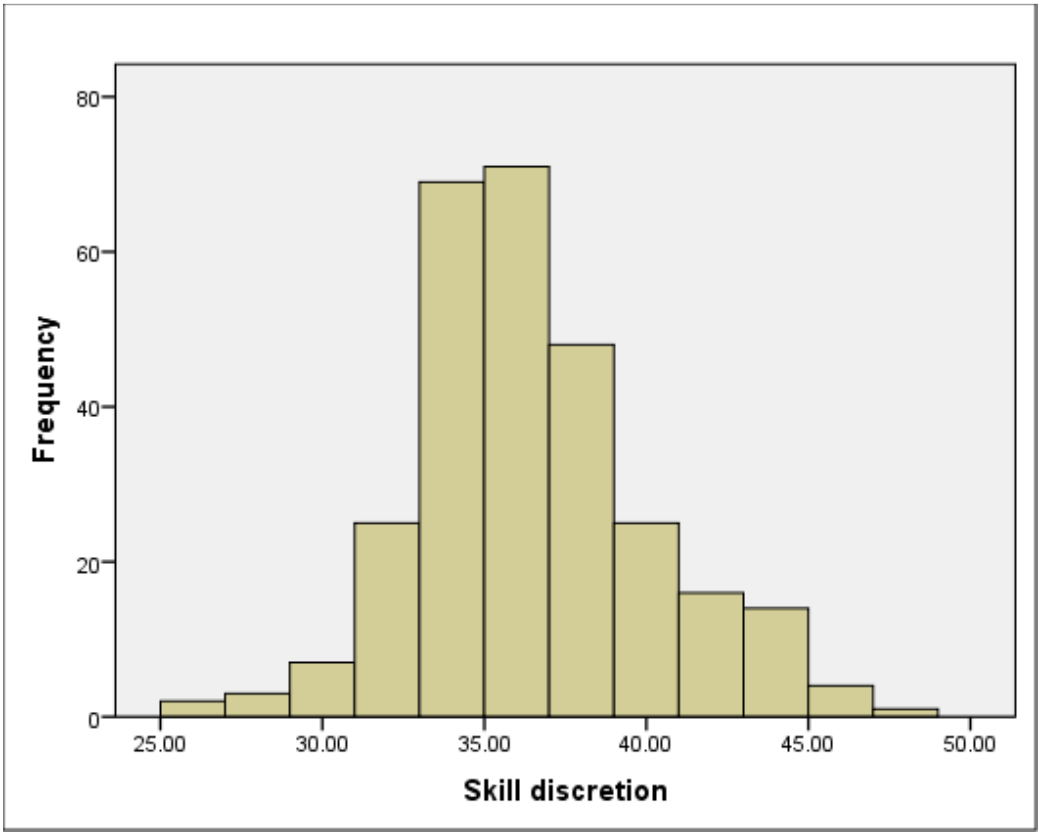
Figure 5.4: Decision latitude/job control histogram



Skill discretion (sub-scale of the job control variable)

This variable is not presented in Table 5.3 however it comprises five items with a mean of 35.62. The standard deviation from this mean was 4.07 and minimum and maximum scores for this were 22 and 48. Only six missing values were recorded. The histogram, Figure 5.5, represents the distribution of the data for this variable. The data appears to have some features of a normally distributed variable, with equal spread around the mean.

Figure 5.5: Skill discretion histogram

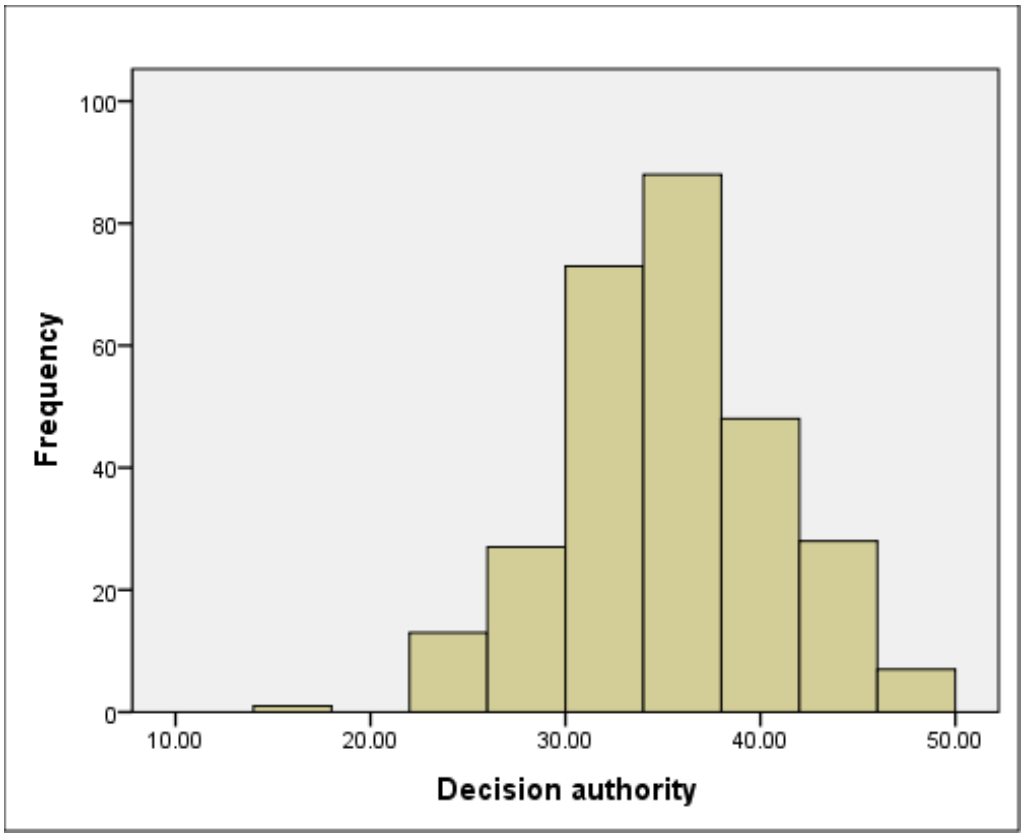


Decision authority (sub-scale of the job control variable)

This variable is also not presented in Table 5.3. It consists of three items and has a mean of 34.73 with a standard deviation of 5.63. The minimum and maximum scores for this variable were 16 and 48 and missing values were again few with only six missing values.

The histogram in Figure 5.6 shows the distribution of the data. There appears to be a slight negative skew with higher results grouped together more to the right of the graph, but otherwise approximates to a normally distributed variable.

Figure 5.6: Decision authority histogram



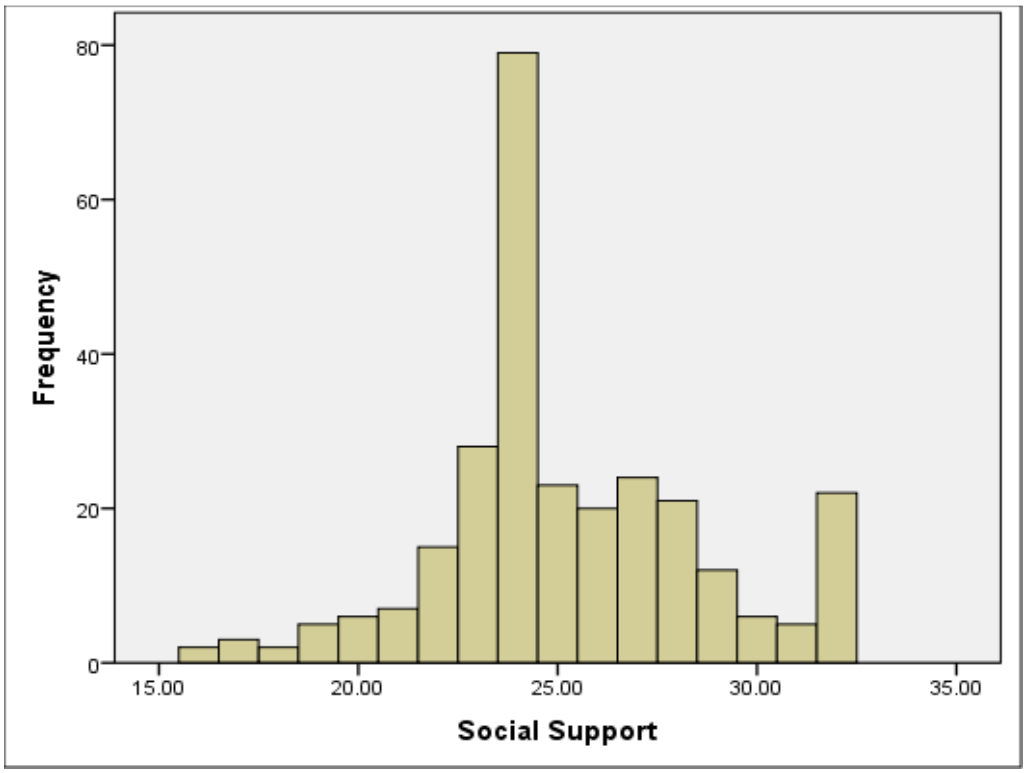
Social support

The social support variable consists of a weighted sum of the co-worker and supervisory support variables. In this chapter the variable has been considered as its two component sub-scales. Here the social support variable as a whole is discussed first followed by the two components.

The mean value for the combined social support variable was 25.19 and the standard deviation from this mean was 3.37. The minimum and maximum scores were 14 and 32 and missing values for this variable were a little higher than for others at 24. The histogram in Figure 5.7 shows that the

social support variable has a negative skew with more observations on the right hand side of the mean in the graph. This is one of the main reasons for breaking down this variable into its two component sub-scales.

Figure 5.7: Social support



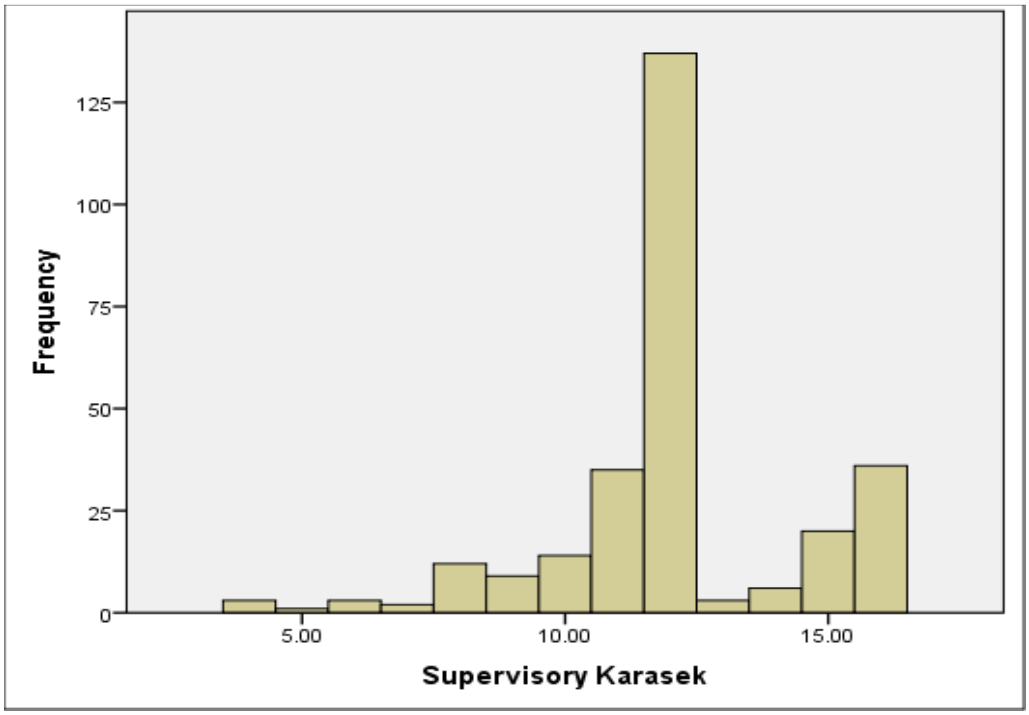
Supervisory support (sub-scale of the social support variable)

This variable consists of five items that measure the respondent's satisfaction with the support they receive from their managers. The summary statistics are shown in Table 5.3. The mean was 12.08 with a standard deviation of 2.5. The minimum and maximum values of this variable ranged between 10 and 16. The number of missing values for this variable was 14.

The histogram, shown in Figure 5.8, graphically displays the spread of this variable with a very high uni-modal peak. There was a slight negative skew with this variable with a long tail of lower score values on the left of the graph. The data for this variable can be used in further analysis but it is worth noting that the spread is not normally distributed. Data collection suggested that

this distribution could possibly be an effect caused by larger organisations such as NHS Trusts having very similar patterns of working.

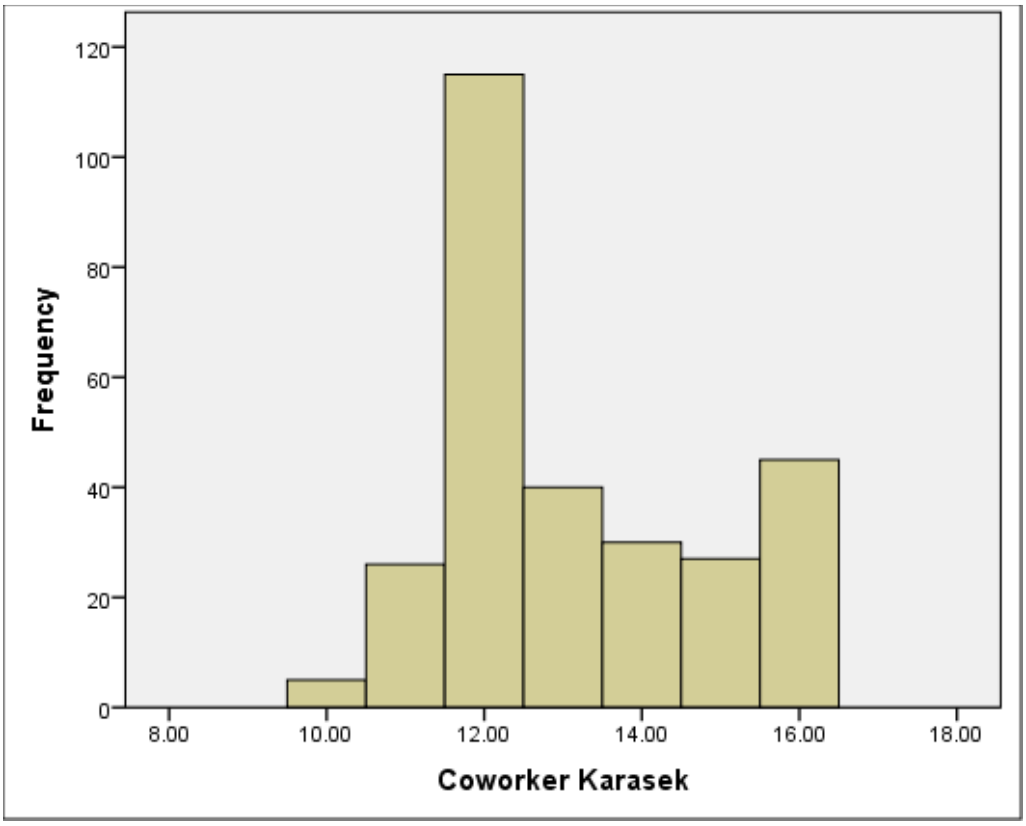
Figure 5.8: Supervisory support histogram



Co-worker support (sub-scale of the social support variable)

This variable has six items and summary statistics can be found in Table 5.3. The value of the mean was 13.13 with a standard deviation of 1.67. The minimum and maximum scores were 10 and 16 with seven missing values. The histogram, shown in Figure 5.9, shows the distribution of this variable has a slight negative skew. The main proportion of answers by respondents were on the right hand side of the graph. The data for this variable can be used for future analysis but it is worth noting that it is not normally distributed.

Figure 5.9: Co-worker support histogram



Internal consistency of the scales

As can be seen in Table 5.3 Cronbach's alpha statistics for all key variables were calculated. For the job satisfaction variable this was not applicable as this is a single item scale only. For all other key variables they met standard thresholds for internal consistency of greater than 0.70, (Wanous et al, 1997). The intent-to-quit variable (two items) had an alpha score of 0.77. The job demands variable (nine items) had an alpha score of 0.79 and the job controls (eight items) was 0.71, but still within the recognised threshold. The supervisory support (five items) and the co-worker support variables (six items) had the highest Cronbach alpha scores of 0.93 and 0.81 respectively.

Correlation coefficients

Pearson correlation coefficients were undertaken and these findings are presented in Table 5.3. These confirmed patterns of expected associations, especially in relation to the job satisfaction variable, which was negatively associated with intent-to-quit. As job satisfaction increased the scoring of intent-to-quit decreased at a statistically significant level (two-tailed Pearson correlation: $r=-0.485$, $p<0.001$). Job satisfaction was also negatively associated with job demands, thus higher job satisfaction was associated with lower job demands, and vice versa (two-tailed Pearson correlation: $r=-0.329$, $p<0.001$). Conversely job satisfaction was positively associated with job controls, so job satisfaction increased as job control scores did (two-tailed Pearson correlation: $r=0.334$, $p<0.001$). Job satisfaction was also positively associated with supervisory support and co-worker support at a statistically significant level. Job satisfaction increased as both supervisory (two-tailed Pearson correlation: $r=0.387$, $p<0.001$) and co-worker support (two-tailed Pearson correlation: $r=0.189$, $p<0.001$) increased.

The intent-to quit variable was positively associated with job demands, hence as job demands increased the higher the intent-to-quit (two-tailed Pearson correlation: $r=0.349$, $p<0.001$). Intent-to-quit was, however, negatively associated with job controls, so as control increased the intent-to-quit decreased. This association was significant (two-tailed Pearson correlation: $r=-0.306$, $p<0.001$). The same was seen with respect to the supervisory and co-worker support variables, both supervisory (two-tailed Pearson correlation: $r= -0.390$, $p<0.001$) and co-worker support (two-tailed Pearson correlation: $r=-0.174$, $p=0.003$) were negatively associated with intent-to-quit at a statistically significant level.

The job demands variable was not statistically significantly associated with other job characteristic variables save for a weak negative association only approaching significance levels with the supervisory support variable. As job demands increased supervisory support decreased however this only approached significance (two-tailed Pearson correlation: $r=-0.109$, $p=0.090$).

Job controls were positively associated with both supervisory support (two-tailed Pearson correlation: $r=0.272$, $p<0.001$) and co-worker support (two-tailed Pearson correlation: $r=0.173$, $p=0.004$) variables at a significant level. Supervisory support was positively associated with co-worker support so the higher the one the higher the other at a significant level (two-tailed Pearson correlation: $r=-0.357$, $p<0.001$).

Table 5.3: Job experience outcome measures: descriptive statistics and correlation coefficients

	Job satisfaction	Intent-to-quit	Job demands	Job controls	Supervisory support	Co-worker support
Summary statistics						
Mean	3.98	4.19	35.66	71.81	12.08	13.13
Standard deviation	1.05	1.43	5.83	8.04	2.35	1.67
Min	1.00	2.00	22.00	48.00	4.00	10.00
Max	6.00	8.00	48.00	94.00	16.00	16.00
Missing	7	7	13	14	14	7
Cronbach alpha	n/a	0.77	0.79	0.71	0.93	0.81
n	288	288	282	281	281	288
Correlation coefficients[T]						
Intent-to-quit	-0.485					
	p<0.001					
Job demands	-0.329	0.349				
	p<0.001	p<0.001				
Job controls	0.334	-0.306	0.049			
	p<0.001	p<0.001	(0.422)			
Supervisory support	0.387	-0.390	-0.109	0.272		
	p<0.001	p<0.001	(0.090)	p<0.001		
Co-worker support	0.189	-0.174	-0.066	0.173	0.357	-
	(0.001)	(0.003)	(0.273)	(0.004)	p<0.001	-

[T] Pearson correlation coefficients (p-values)

Descriptive tables

Mean values for job satisfaction, intent-to-quit and the psychosocial characteristics of work across a range of personal characteristics are presented in Table 5.4. In Table 5.5 mean values for these key variables can be seen across a range of team-related characteristics. Tests of the relevant associations of the variables were also undertaken and are described below where these reached statistical significance. The following sections are organised by variable.

Age

The dataset revealed that there were limited differences in means across the differing age categories and outcome and job characteristics variables. No statistical differences were evident in the data (ANOVA tests of association).

Gender

Women tended to report better job characteristics than men, this was shown with slightly higher mean job satisfaction scores in women (4.05) than men (3.73) at a statistically significant level (two-tailed t-test: t=2.150, df=286, p=0.032). Women also reported increased levels of job controls than men, 72.62 to 68.83 respectively (two-tailed t-test: t=3.294, df=279, p=0.001). Women too had higher supervisory support than men, 12.23 to 11.54, and this was again significant (two-tailed t-test: t=2.031, df=279, p=0.043).

Employment status

There were limited differences across the main variables in the employment status categories and outcome and job characteristics variables. No associations were evident in the data when conducting t-tests of association.

Professional group

For the professional group variable there were significant variations in job satisfaction means for the differing professional groups (ANOVA: F=2.96, df=6, p=0.008). Using post hoc tests social workers reported lower job satisfaction than support workers (Bonferroni: p=0.030) and ‘other disciplines’

(Bonferroni: p=0.026). Similar findings were present with the intent-to-quit variable (ANOVA: F=3.02, df=6, p=0.007), with social workers reporting greater intent-to-quit than support workers (Bonferroni: p=0.007).

With regard to the job demand variable this also varied across professional groups (ANOVA: F=10.911, df=6, p<0.001). Support workers reported lower job demands than all other staff groups (Bonferroni: p<0.001 in all cases, except doctors: p=0.035) and team managers reported higher job demands than doctors (Bonferroni: p=0.026). Job controls varied significantly (ANOVA: F=5.977, df=6, p<0.001). Team managers reported higher job controls than nurses (Bonferroni: p=0.011), social workers (Bonferroni: p<0.001), support workers (Bonferroni: p=0.003) and occupational therapists (Bonferroni: p=0.002). Social workers reported lower job control than nurses (Bonferroni: p=0.032) and other staff (Bonferroni: p=0.002). There were few professional group differences with respect to supervisory and co-worker support, but none of these reached statistical significance.

Active caseload

For this variable there was a slight negative association between caseload size and job satisfaction, with the job satisfaction variable ranging from 4.15 to 3.71 between those with the lowest and highest caseloads. The caseload variable was treated as continuous for the purposes of this analysis. This association only reached significance when doctors were excluded from the analysis, as they had much higher caseloads (two-tailed Pearson correlation: r =-0.153, p=0.017). There were few other differences in the key variables with none reaching statistical significance.

Time in team

There were few associations evident between the length of time respondents had worked for the team and other job characteristics or outcome variables. Examining the means there was some suggestion that job controls increase with time spent in the team, but this did not reach statistical significance.

Team size

For the team size continuous variable there were few differences across the key variables of job satisfaction, intent-to-quit and job outcome domains. Furthermore, team size was not significantly associated with these, despite the hypothesis that larger teams may have inferior supervisory support.

All time spent in the team

For this variable respondents were asked whether they worked only for the CMHTsOP in question, or had additional responsibilities elsewhere. There were few differences in any of the key job outcome variables and although there was slightly improved supervisory and co-worker support for respondents who worked solely for the CMHTsOP, this did not reach statistical significance.

Team manager same discipline

For a sub-set of respondents a separate variable was computed that explored the implications of having a team manager from the same or different professional discipline. The variation in the means suggested higher job outcomes where staff had managers of the same discipline: job satisfaction (two-tailed t-test: t=3.220, df=159, p=0.002); the intent-to-quit variable (two-tailed t-test: t=2.572, df=161, p=0.011) and job controls (two-tailed t-test: t=3.183, df=159, p=0.002) showed these. All other associations did not reach statistical significance.

Table 5.4: Job experience outcome measures: Personal characteristics (ANOVA and t-tests)

		Job satisfaction	Intent-to-quit	Job demands	Job controls	Supervisory support	Co-worker support
		Mean	Mean	Mean	Mean	Mean	Mean
Age	< 35	3.94	4.49	34.68	71.58	12.42	13.26
	35 – 44	4.12	4.05	35.38	71.31	12.30	13.19
	45-54	3.96	4.20	36.39	72.34	12.02	13.04
	55 +	3.87	4.13	34.98	71.78	11.70	13.19
Gender	Male	3.73	4.30	35.50	68.83	11.54	12.81
	Female	4.05	4.16	35.71	72.62	12.23	13.22
Professional group	Doctors*	4.00	3.92	34.33	72.00	11.33	13.17
	Nurse	3.90	4.32	36.59	71.83	12.27	13.00
	Occupational Therapist	3.68	4.57	37.46	69.17	11.92	13.12
	Social worker	3.41	4.91	36.68	65.90	11.43	12.68
	Support worker	4.29	3.57	29.97	70.34	12.37	13.60
	Team Manager	4.15	4.00	39.28	77.76	11.92	12.92
	Other disciplines[†]	4.34	4.13	35.34	74.73	12.28	13.45
Employment status	Full time	3.99	4.19	35.84	71.94	12.11	13.20
	Part-time	3.97	4.16	35.16	71.57	12.07	13.00

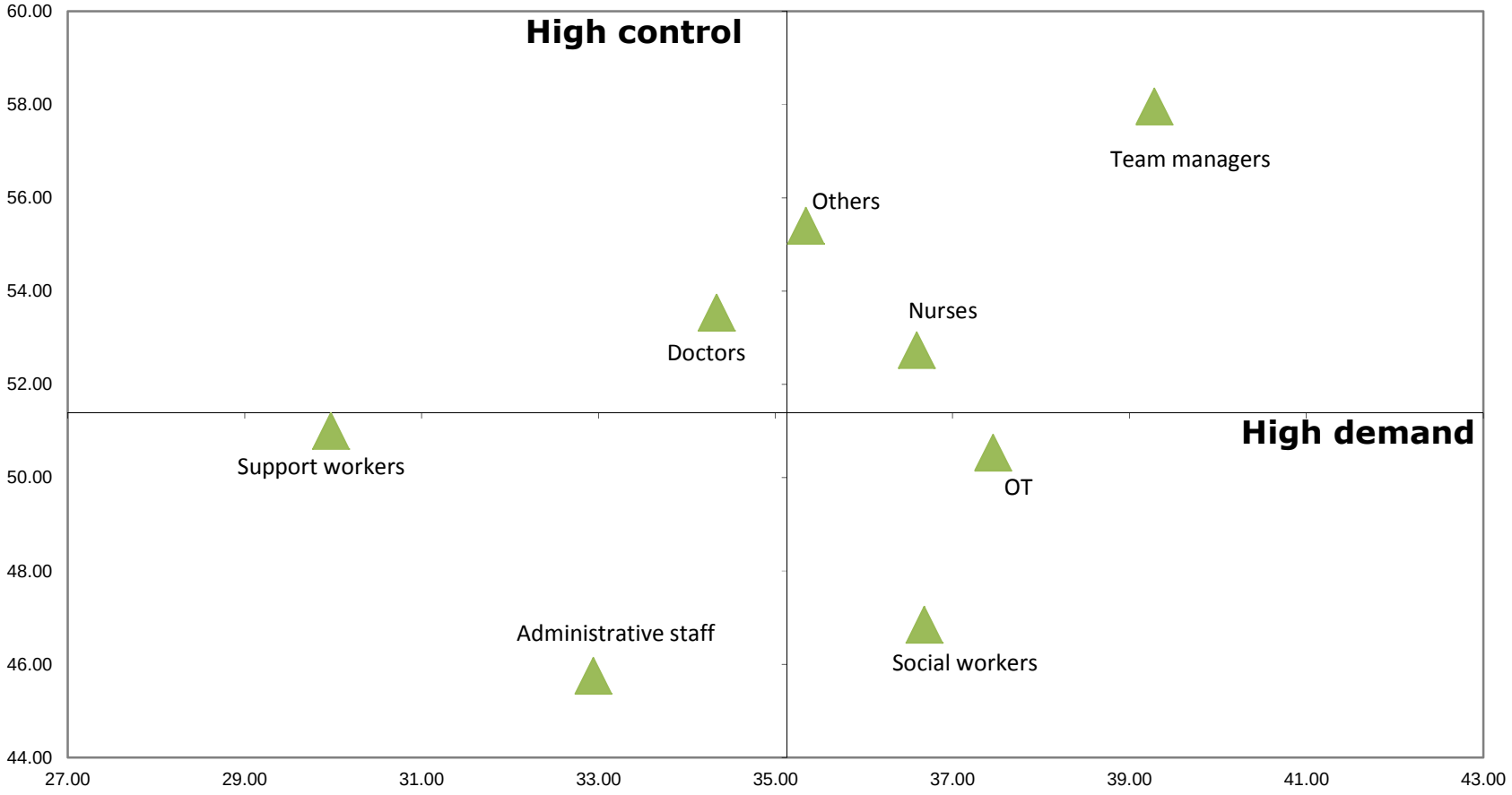
[†]Other disciplines comprising Psychologist, Physiotherapist and 'any other' discipline category. *Consultant psychiatrists and doctors

Table 5.5: Job experience outcome measures: Team-related characteristics

		Job satisfaction	Intent-to-quit	Job demands	Job. controls	Supervisory support	Co-worker support
		Mean	Mean	Mean	Mean	Mean	Mean
Active caseload	<15	4.15	3.98	34.84	73.91	12.16	13.16
	15-24	4.12	4.08	34.46	71.65	11.99	13.25
	25-34	4.06	4.18	37.28	70.11	12.25	13.25
	35-44	3.79	4.60	37.18	71.50	12.81	12.97
	45+	3.71	4.23	35.74	73.09	11.73	12.91
Time in team	< 2 years	4.21	4.03	35.10	70.78	12.20	13.22
	2 – 5 years	3.74	4.40	36.40	71.36	12.16	12.94
	6 – 9 years	4.11	4.34	35.45	72.00	11.59	13.07
	10 years +	4.00	3.93	36.38	73.17	12.17	13.23
Team size	<=10	4.03	4.10	35.65	73.13	12.16	13.22
	11-15	3.86	4.40	35.71	70.76	11.99	13.00
	16-20	3.99	4.08	35.52	72.12	12.10	13.25
	21+	4.18	4.02	35.80	72.44	12.16	13.12
All time spent in team	Yes	3.98	4.19	35.68	71.72	12.15	13.14
	No	4.10	4.31	35.96	71.61	11.67	12.96
TM same discipline[†]	Yes	4.02	4.20	36.59	72.39	12.32	13.13
	No	3.52	4.75	36.93	68.43	11.83	12.78

[†] Variable identifies whether the team manager is of the same professional discipline as the respondent, and is only applicable to nurses, social workers and occupational therapists (n=166).

Figure 5.10: The job demand and control cross with respondents professional groups



5.4 Job demands and job control

Further to the description of the Demand/Control diagram presented in Chapter 2, Figure 5.10 plots the equivalent data from the CMHT dataset. In this 'cross', different professional group responses have been plotted on these two axes. This indicates where each professional group scored on the job demands and job control questions relative to others. The intersection of the demand and control axes is at the sample mean for each variable.

As expected, those roles that contain low job demands and low levels of control are situated in the bottom left quadrant of the cross. These include administrative staff (albeit excluded from later analysis). Support workers scored higher levels of job control but lower levels of job demands. This support worker role will be further explored in the interviews with staff later in this chapter. Doctors scored in the top left quadrant with relatively high job control but middle levels of job demands, in relation to other professional groups.

In the top right hand quadrant the 'other' category, predominantly physiotherapists and psychologists, has moderate levels of demands but higher levels of job controls. Similarly team managers score very highly on job demands but this possible negative effect is alleviated by high levels of job control. Nurses are found in this top right quadrant with reasonably high job demands and reasonably high controls. This quadrant can be seen as representing stimulating work but without many of the features of stress due to the protective nature of higher job controls over job demands, see Chapter 2.

In the high strain quadrant, which makes up the bottom right quadrant of the cross (see Chapter 2, Figure 2.2), occupational therapists have relatively high demands but lower levels of job controls. Social workers have relatively high demands in their workload but also much lower levels of job control. One would expect these workers to have the worst job satisfaction scores

and a less positive view on their work, which will be explored further in the qualitative interview section below.

5.5 Bivariate analysis - team type

A main aim of this thesis is to explore the effect of differing team types on workplace wellbeing. This section looks at the association between the degree of team integration and job outcomes. Table 5.6 displays the survey respondents' personal and team-related characteristics in relation to three categories of integration score (low, medium and high) and any associations between these are also displayed. Table 5.7 presents the integration levels of 'low', 'medium' and 'high' in relation to job related outcomes of job satisfaction, intent-to-quit, and the key job outcome domains. Any associations between these are also described.

Key variables

Variables have previously been outlined and can be found in Box 5.2 at the end of this chapter.

Results

In Table 5.6 there were no statistically significant findings between the variables of age, gender, professional group in relation to integration scores. However, there were some associations between the employment status of full or part-time and the three integration categories. These were, however, only approaching significance (Chi squared: x^2=5.183, p=0.075).

For the team-related characteristics, only team size had a statistically significant association with integration categories. Higher team size was found in the low integration category than in the high integration category, 18.52 versus 13.20 respectively. (ANOVA: F=16.000, df=2, p<0.001).

Table 5.6: Integration levels: Personal and team-related characteristics (ANOVA and Chi-squared tests)

		Low integration	Medium integration	High integration	F or x^2 test	p-value
Personal characteristics						
Age (Count)	< 35	7	24	6	x^2= 3.784	0.711
	35 – 44	15	53	12		
	45-54	32	71	26		
	55 +	11	30	6		
Gender (Count)	Male	12	37	15	x^2= 2.354	0.308
	Female	54	141	36		
Professional group (Count)	Doctor	5	17	5	x^2= 11.840	0.459
	Nurse	26	71	21		
	Occupational therapist	6	15	4		
	Social worker	4	10	9		
	Support worker	8	30	5		
	Team Manager	8	16	3		
	Other disciplines†	9	19	4		
Employment status (Count)	Full time	55	127	36	x^2= 5.183	0.075
	Part-time	9	48	15		
Team-related characteristics						
Active caseload	Mean size	39.34	36.91	30.67	F= 0.470	0.625
Time in team	Mean years	6.82	6.31	6.26	F= 0.209	0.812
Team size	Mean size	18.52	16.37	13.20	F= 16.000	p<0.001
All time spent in team (Count)	Yes	57	139	41	x^2= 1.393	0.498
	No	8	32	9		
TM same discipline‡ (Count)	Yes	23	54	17	x^2= 5.000	0.544
	No	13	42	17		

†Other disciplines comprising Psychologist, Physiotherapist and 'any other' discipline category. ‡Variable identifies whether the team manager is of the same professional discipline as the respondent, and is only applicable to nurses, social workers and OTs (n=166)

Table 5.7: Integration and job related outcomes (ANOVA)

Integration‡	Low integration	Medium integration	High integration	F value	p-value
	Mean	Mean	Mean		
Job satisfaction	4.19	3.94	3.86	1.674	0.189
Intent-to-quit	3.79	4.30	4.35	3.469	0.032
Job demands	35.87	36.09	35.66	0.887	0.413
Skill discretion	36.67	36.55	35.88	0.754	0.471
Decision authority	36.19	35.48	33.79	2.697	0.069
Job controls	72.87	72.02	69.70	2.211	0.111
Supervisory support	11.81	12.25	11.81	1.192	0.305
Co-worker support	13.20	13.12	13.06	0.103	0.902
Social support	25.10	25.41	24.88	0.552	0.577

‡Categorisation of integration score: Low (1-3); Medium (4-6); High (7-9)

In Table 5.7 the job outcomes for respondents working in teams with different levels of service integration are outlined. Respondents who worked in high integration teams tended to have slightly worse job outcomes, with lower job satisfaction, higher intent-to-quit scores, and reduced job controls. These differences were relatively small and the majority did not reach significance with only the intent-to-quit variable reaching statistical significance (ANOVA: F=3.469, df=2, p=0.032).

5.6 Regression results

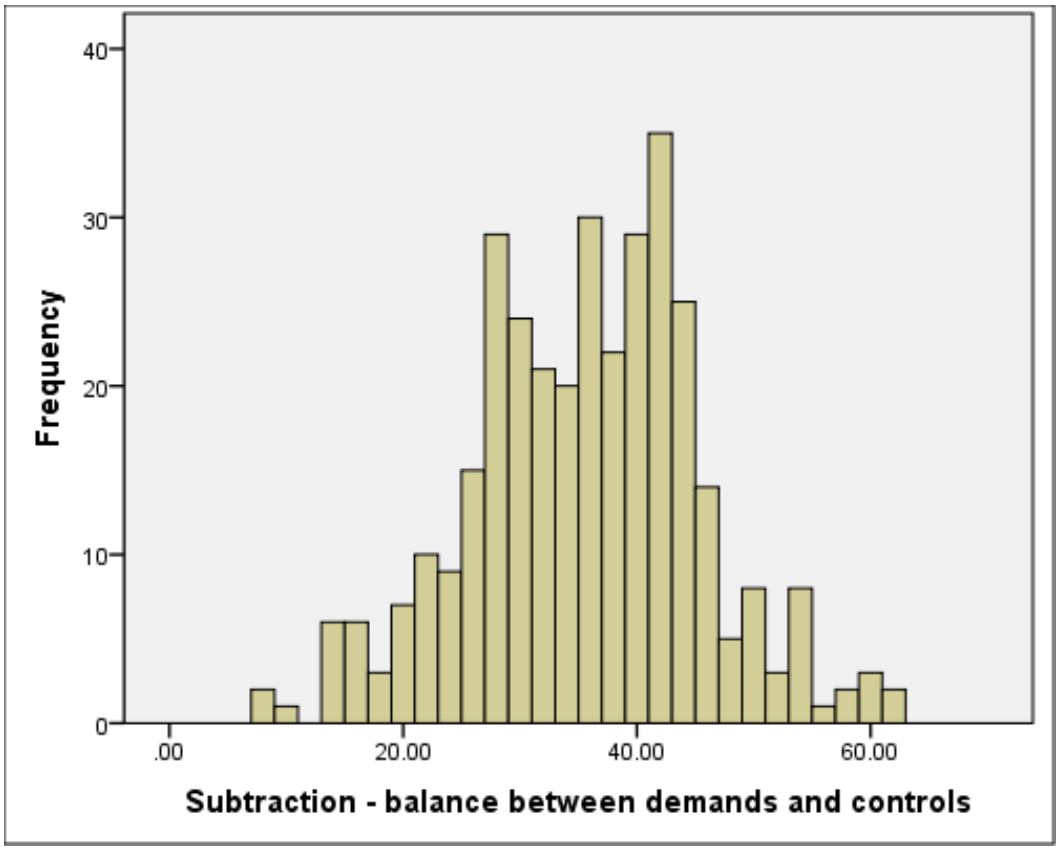
As can be seen from the literature review (Chapter 2) there is a well-established association between the balance of job demands and job controls on workplace wellbeing. A new 'net job demands' variable, outlined below, was employed as the dependent variable in these analyses and any associations with the integration variable are explored further. Other new variables constructed for use in this model are also described and summarised in Box 5.2 at the end of this chapter.

New variables

A new variable was computed called the net job demands variable. This comprised the arithmetic difference between job controls and job demands,

therefore job demands minus job controls. Basic summary statistics of this variable showed a mean of 35.12 and standard deviation of 9.78. Minimum and maximum scores were 8 and 62. There were 25 missing values for this new variable. For this net job demands variable larger values indicated greater controls relative to demands for respondents in the sample as a whole.

Figure 5.11: Histogram of the net job demands variable



The histogram, Figure 5.11, showed some characteristics of a normal distribution of the responses. The standard bell shaped distribution curve is displayed and responses are spread evenly either side of the mean value.

The job security variable comprised one item and was included in the analysis due to the level of organisational uncertainty in the participating Trusts at the time of data collection. Many CMHTsOP were undergoing

some level of change and therefore respondents were asked to rate to what extent would they agree that their job security was good (strongly agree and agree were coded together as 1, disagree and strongly disagree were coded together as 0). This was included in this regression as a binary variable.

A variable was computed which was relevant only to respondents with a nursing professional background. This variable was called 'nurse managed by non-nurse' and was included in the model as it might have an impact on the net job demands variable (balance of demands and controls) of respondents. This variable was computed from original raw variables and was a binary variable coded as either yes (nurse managed by nurse) or no (nurse managed by non-nurse).

A final variable was that of caseload size for professional groups, namely the interaction term of caseload size multiplied by professional group for three disciplines (nurse, occupational therapist and social worker).

Stepwise ordinary least squares (OLS) regression

Stepwise Ordinary Least Squares regression analysis was undertaken to estimate the contribution of team integration to the net job demands variable (balance between job demands and controls), Table 5.8.

At the simplest level, without adjusting for the influence of other variables or confounding factors, Block A indicated that working in a high versus a low integrated team was associated with a poorer balance of demands and controls. Block B included gender and professional group variables in the regression, and suggested that women showed improved balance between demands and controls relative to men, and occupational therapists and social workers reported a poorer balance relative to all other professional groups. In this block it can be seen that controlling for gender and professional group reduced the effect of working in a high integration team.

Block C suggested that respondents who had worked within their team longer reported a better demand/control balance than staff that had recently joined the team. Caseload size was not found to be a significant determinant. One possible reason is that doctors, support workers and team managers did not show the conventional association between high caseload size and increased job demands, because of the nature of their job roles. However, an interaction between caseload size and being a nurse, social worker or occupational therapist demonstrated a slight negative association with the demand and control balance.

The final model (Block D) included an interaction term indicating nurses who were managed by a non-nurse, and suggested that for this group, those who were not managed by someone from a similar profession faced a significantly inferior demand and control balance than other staff with managers of the same professional background to them. Unfortunately, testing for this interaction effect could not be extended to other staff groups due to small cell sizes. Job security was positively associated with improved demand and control balances, with a substantial effect size and associated increase in the model fit. Following the inclusion of all significant indicators, the impact of team integration on demand/control balance was negligible. As this was a key variable of interest in the study the implications of this will discussed in the final chapter of this thesis (Chapter 7).

Table 5.8: Least squares regression of demand and control balance and variables of interest

MODEL		Block A			Block B			Block C			Block D		
		Coeff	St. Err	p-value	Coeff	St. Err	p-value	Coeff	St. Err	p-value	Coeff	St. Err	p-value
Integration	Low	[ref]			[ref]			[ref]			[ref]		
	Medium	-1.960	1.45	0.179	-1.760	1.41	0.212	-1.077	1.46	0.461	0.230	1.43	0.872
	High	-4.558	1.90	0.017	-3.334	1.86	0.074	-0.286	1.99	0.886	0.740	1.95	0.705
Gender	Male				[ref]			[ref]			[ref]		
	Female				3.404	1.37	0.014	2.472	1.45	0.076	2.452	1.39	0.080
Professional group	Social worker				-7.142	2.21	0.001	-7.977	2.41	0.001	-6.956	2.34	0.003
	OT				-5.817	2.01	0.004	-5.908	1.93	0.003	-6.036	1.88	0.002
Time in team								0.261	0.11	0.015	0.229	0.10	0.029
Caseload size								0.010	0.01	0.471	-0.002	0.01	0.881
Interaction: Caseload size x (nurse/OT/social worker)								-0.055	0.03	0.045	-0.047	0.03	0.073
Nurse managed by non-nurse								-5.225	1.82	0.005	-6.126	1.76	0.001
Job security											3.245	0.76	<0.000
Constant		38.167	1.25	<0.000	36.206	1.655	<0.000	35.877	2.03	<0.000	27.793	2.65	<0.000
n		275			275			229			223		
Diagnostics													
R^2		0.021			0.098			0.165			0.249		
Adjusted R^2		0.014			0.082			0.130			0.214		
Shapiro-Wilk (residuals)		W=0.992, p=0.130			W=0.995, p=0.518			W=0.994, p=0.449			W=0.992, p=0.315		

5.7 Staff interview results

Interviews were also undertaken with staff in CMHTsOP to capture the experience of working in different team settings. These were with a sub-sample of nurses, social workers, occupational therapists and support workers from nine of the CMHTsOP included in the study. The interviews were focussed on part of a wider body of work; however there were questions relevant to the key variables of interest in this thesis. Specifically, the interviews explored: job demands on staff (pressures and frustrations with their professional identity and generic working were detailed); job controls (especially the extent and nature of work autonomy); supervisory and co-worker support received from respondents' peers, consultants and managers; the balance between support and control; and job satisfaction. These interviews also included an exploration of the impact of team arrangements on staff wellbeing; whether respondents felt that their contribution to the team was valued; respondents were also asked to state what they found most rewarding about their work. Quotations illustrating these findings can be found in Box 5.1.

Job demands

Many of the pressures faced by CMHTsOP respondents were similar across team types of both high and low levels of team integration. These were listed as: increased workloads; lack of resources available; bureaucratic demands from higher up in the organisations, and uncertainty about the future. As the teams were undergoing a great deal of change these pressures were heightened at the time of interviewing. There were also some organisational features that resulted in particular frustrations. Respondents in low integrated teams frequently reported difficulties when trying to contact social workers in local authorities. These difficulties included wasted time and lost information resulting from centralised access systems that were increasingly being used by social services departments. The lack of understanding of mental health issues they encountered when working with generic social workers was an additional frustration and can be seen in Quote 1. Another

main frustration was expressed by staff in CMHTsOP where consultants did not have inpatient responsibilities, who felt that this resulted in ward staff placing unreasonable demands upon them. There were also difficulties noted by interviewees arising from the centralisation of inpatient beds within geographically large Trusts (Quote 2).

Job control

Interviewees mostly reported a high level of autonomy (otherwise known as the level of job control that was available to them in their professional role). This level of job control varied, the greatest being amongst psychologists and the least (although still felt to be substantial) amongst support workers. Amongst nurse respondents an example was given of job control being greater than on hospital wards, something described as both rewarding and challenging (Quote 3). Social workers all reported experiencing greater job control working within their CMHTsOP compared with working in generic social services teams (Quote 4). Respondents tended to distinguish between autonomy that took the form of flexibility to 'run their own diary' (a support worker) and that which related to having authority to make decisions. Most respondents reported the former to be the norm in their teams although there were examples of this practice being undermined by the pressures of increased workloads and the use of electronic diaries which resulted in respondents feeling 'watched' and 'not trusted' by senior management (a Nurse). Respondents also reported that they had less authority to take decisions than in the past, and a perceived increase in pressure to improve speed and 'throughput' of cases (Quote 5).

Supervisory and co-worker support

Most respondents described working in highly integrated teams in a positive light, particularly the support they received from other disciplines. They mainly reported being part of a team that worked well together; having knowledge and understanding of each other's caseloads and pressures; having shared joint working goals; and making decisions as a team (Quote

6). Staff stated they tended to support each other informally, although formal forums for case discussions were reported to be lacking in a small number of teams. This was reported as reducing effective team working leading to poorer understanding between disciplines and team members working in isolation (Quote 7).

Respondents stated that both team managers and consultants played an important role in influencing team climate. Having an accessible and approachable consultant was important in enabling team members to make decisions safely. Many respondents described their consultants treating different professional team members as equals and valuing their expertise. A minority found their consultant more difficult to approach and did not feel their views were listened to, resulting in both frustration and anxiety. Most respondents also reported good support from their team managers. Two factors appeared to influence this: whether the team manager had the same professional background as the respondent; and whether their team manager carried a caseload. Views on the effect of carrying a caseload were contradictory with some respondents believing it helped the team manager to understand the clinical work of their staff and the pressures they faced. Other respondents felt it resulted in managers not having enough time for team management issues and responsibilities.

Respondents' views also varied in relation to how important the professional background of the team manager was to their feelings of support. Some respondents suggested that characteristics in their manager such as empathy were more important, whilst others thought that better support would come from a manager who shared their professional background (Quote 8).

Balance between support and control

Respondents reported that achieving an appropriate balance of independent working (job control) and support was vital to how they felt (Quote 9) and this varied between professional groups. Respondents felt that too little guidance

and oversight from supervisors and managers, particularly for support workers, could lead to feelings of isolation and anxiety. Psychologists also noted that their relative autonomy (job control) created a divide between them and the rest of the team (Quote 10).

Job satisfaction: in relation to team integration level and professional identity

How satisfied respondents were working in teams with differing levels of integration was discussed, especially with regard to more generic team working (higher integrated teams) versus lower integrated teams. The professional background of respondents made a large difference in how they viewed working in their team and was also a large factor in their satisfaction levels within teams. Social workers and occupational therapists were the most vocal about both the strengths and weaknesses of generic working in highly integrated teams. Some found working in this way a positive experience which enhanced their role and fostered effective team working (Quote 11). Others, including psychologists, were concerned that this practice resulted in the loss of valuable specialist expertise with staff in the teams not being able to use their skills effectively (Quotes 12 and 13). Respondents expressed concerns in particular about the expectation to monitor medication and their role. Most described feeling that their contribution was valued by their colleagues. Some psychologists and social workers however felt that their role was misunderstood, resulting in the under-use of their skills (Quote 14).

Respondents described support workers as having an enviable role within the teams, as they tended to take on all the most fulfilling aspects of direct work with service users that professional staff no longer had time to do (Quote 14). Support workers also recognised this, describing their work positively in terms of both its value and their own satisfaction (Quotes 15 and 16). This role was not always positive, however, as there were examples of support worker respondents who felt they were sometimes used inappropriately, for example as a transport service or as a substitute for

qualified nurses. The view that support workers were only allowed to take on this level of work when it suited management, at other times being told that they did not have the expertise required was an additional source of frustration (Quote 18).

The extent to which respondents expressed a desire to retain their professional identity varied between respondents and did not relate to any specific team type (high or low integration). Occupational therapists and psychologists appeared to have the strongest sense of professional identity, although among occupational therapists this was not seen to conflict with also having a strong team identity as well (Quotes 19 and 20). Social worker respondents referred to having a dual or blurred identity, as both social workers and also mental health workers (Quotes 21 and 22). Nurse respondents tended to refer to working as part of a team, and to getting the job done. Most interviewees were comfortable with the level of integrated working in their team and were satisfied although some were clear that they did not want this to go further.

Conclusion for staff interviews

Every respondent that was interviewed stated that they gained immense satisfaction from the role they played in helping people to get better or improve their circumstances. Most spoke with enthusiasm for their work and about their team. In particular, working in high integrated teams was described as being interesting and rewarding, providing opportunities for them to learn from others and to impart their own knowledge and skills to colleagues (Quote 23).

Box 5.1: Quotes from qualitative interviews

	Theme	Quote	Respondent Team Type and Professional Group
1	Job demands	They've put everything down to one number where people take referrals… We have to refer everything through this central control…Sometimes they will then phone the … patient, say they've been referred … I've gone out and seen the lady…I've just done this, this week, … she has dementia … So I put in a referral, which she was agreeable, ….Now if they ring her and say "we've had a referral from [the CPN]" she'll say "no I don't want it" because she would have forgotten and then they've just closed the case and then you have to go through the whole process again	Team H 'Low Integration', Nurse
2	Job demands	…it's the time factor. Things have to change on how we do the ward rounds…. I mean, I've got a couple over in [place name], and I need to go over three times a week for [each] review it's like three or four hours taken out of my working day, three times a week. You can't sustain that.	Team A 'High Integration', Nurse
3	Job control	…there is so much more flexible… If it is within the ward you have an admission, an assessment, you have … got … a pathway …. whereas there are so many things that can change within the community…very enjoyable	Team D 'High Integration', Nurse
4	Job control	…that is one of the huge bonuses of working at the CMHT … I do feel that I have quite substantial autonomy.	Team A 'High Integration', Social worker
5	Job control	Sometimes you get the feeling that you are not really trusted, that your professional judgement isn't perhaps trusted…I think things have got worse recently, because of cut backs and spending restrictions, I'm not…, certainly my feeling is that it's a lot more tense about things, and there's a lot more making sure that, not only we're doing our jobs properly, but that we all gets seen by the 'powers that be', to be doing our jobs properly	Team C 'High Integration', Nurse
6	Supervisory and co-worker support	…this is an excellent team, and we really do work together. The thing I like about our team is that we discuss every person. It isn't a case of she has her ten patients, she has hers, she has hers, and she has hers.., everybody talks about them, and we value each other's opinions, so it really is, we pull together everyone	Team D 'High Integration', Support worker
7	Supervisory and co-worker	One of the things I would like to do is … facilitate kind of case discussion groups where it's not about people necessarily passing the work on to someone else but just being able to just brainstorm and think together and draw on each others' experience and skills. I think that would be really valuable…	Team F 'Low Integration', Psychologist

	support		
8	Supervisory and co-worker support	I think it's the understanding of what the job actually is. If it was a Nurse Manager they would have the similar background training and things to yourself, and they would have probably different expectations or an understanding of a problem that you are discussing	Team H 'Low Integration', Nurse
9	Balance between support and control	Yes you can (make decisions) , and that's good, but the thing is that if you're worried about it you've always got the team backup and the support of your managers as well to discuss with them	Team I 'Low Integration', Nurse
10	Balance between support and control	It does kind of set me apart from the rest of the team in some ways. So I am sort of protected from some of the stresses and pressures that other team members have…but there are disadvantages …sometimes I am seen as being a bit separate from the team, and perhaps not understanding the pressure that they are under…	Team F 'Low Integration', Psychologist
11	Job satisfaction	When cases are being allocated you can lend yourself to a lot more problems than maybe you would initially have thought you would…	Team A 'High Integration', Occupational therapist
12	Job satisfaction	…the OT and Nurse [role] overlap …maybe the OT skills don't get used as specifically as they could be	Team I 'Low Integration', Psychologist
13	Job satisfaction	I sort of feel that we've got different skills and we should use them and, perhaps for the patient, it's the best person for the job depending on their problems	Team B 'High Integration', Occupational therapist
14	Job satisfaction	Our role is to go in and set up services and monitor the services, not to provide the ongoing support, and I think that there is a bit of confusion around that because some of the grumbles if you like have been, - "well I've been to see this person and social worker hasn't had any contact with them", but when you unpick it … there's actually no need for the social worker to have any contact, but the CPN hasn't … understood that that is not what we do	Team B 'High Integration', Social worker
15	Job satisfaction – support worker	I quite envy their role really… it is quite an enviable role, it is very…hands on…as a professional I do an initial assessment and then you are sending other people out …	Team D 'High Integration', Social worker
16	Job satisfaction –	I think I have got a real good role, I work amongst all these professional people, that treat me equally, and that is a good feeling	Team C 'High Integration',

	support worker		Support worker
17	Job satisfaction – support worker	[I know] that I'm making a difference to their lives. I know that sounds big headed, but I know I am. I couldn't do it if I wasn't. I never finish the day thinking that I haven't helped them people.	Team F 'Low Integration', Support worker
18	Job satisfaction – support worker	I am told I can't do assessments…[The team manager] asked if I could go out and see these two people and I said no…. that is not my responsibility … I refused.....I am told I can't do things on one hand, but then again when it suits… it is all right to bring me in.	Team H 'Low Integration', Support worker
19	Job satisfaction – professional speciality	My main focus is this team…When I am doing generic work I am always an OT as some level. I'm quite comfortable with that	Team H 'Low Integration', Occupational therapist
20	Job satisfaction – professional speciality	I'm very proud of being an OT. I would say OT first, team second …	Team I 'Low Integration', Occupational therapist
21	Job satisfaction – professional speciality	I've always had a dual role… as a mental health professional and as a social worker ….	Team A 'High Integration', Social worker
22	Job satisfaction – professional speciality	Where initially it was about procurement and care management, now it's much more inclusive, much more … monitoring through peoples mental health, looking at medications, so the role has expanded and taken it away from traditional social worker role and it is much more blurry now with health… Though there are these blurrings around the edges…people still have certain specialisms	Team C 'High Integration', Social worker
23		When … you're in this situation, you take obviously the small victories, because for some people particularly with a dementia diagnosis.., then obviously the future is very bleak, so in those situations you get joy from the small victories like getting an extra day at day care so that the carer has got an extra day to recharge their batteries, or you manage to get a particular home care service in which means the client's dignity is protected … Obviously with functional illnesses you can have complete turnaround…someone can be suicidal, then six months later they can be up and about and doing what they have always been doing. Without a doubt, that's the best type and you do, you get quite emotional. .... it's quite journey that you take with someone emotionally so when they do improve … it's a massive source of joy and fulfilment so that's definitely the best bit.	Team C 'High Integration', Nurse

5.8 Summary

This chapter has described the CMHTsOP dataset and all the analyses that have been undertaken on the variables in this. It details both the questionnaire and the qualitative interviews. Data management details have been outlined and any changes noted. Descriptive analyses indicated that respondents in multi-agency teams had significantly higher intent-to-quit scores and an increased chance of having a job demands and control balance that was poorer than respondents in single agency teams. Stepwise ordinary least squares regression showed that these team type effects were reduced when all other variables were controlled for. The management structure had more of an impact upon the balance of demands and controls, for example the effect of a difference between a respondent's professional background and that of their team manager. The staff interviews also found that those respondents working in single agency teams had more difficulty accessing social services support but overall respondents supported multi-agency working. The next chapter (Chapter 6) will present findings from the combined datasets of Chapter 4 and 5 and these will be discussed.

Box 5.2: A list of variables in Chapter 5

Variable	How it has been used
Age	Categorical variable: <35 (less than thirty five); 35-44; 45-54 and 55+ (fifty five and over)
Gender	As in Chapter 4, Box 4.1
Professional group	Tick box yes/no binary variable: • Doctor (comprised consultant psychiatrist and doctor) • Nurse • Occupational therapist • Social worker • Support worker • Team manager • Other (comprised psychologist, physiotherapist and other)
Employment status	Categorical binary variable: Full time/part-time
Caseload size	Continuous variable originally but also coded into categorical variable: <15 (less than fifteen); 15-54; 25-34; 35-44; 44+(forty four and over)
Years employed in team	Continuous variable originally but coded into categorical variable:< 2 years (less than two years); 2-5; 6-9; 10+(ten and over)
Team size	Continuous variable (telephone interview) recoded into categorical variable: <=10 (less than or equal to ten); 11-15; 16-20 and 21+ (twenty one and over)
Integration category	Continuous variable originally collected from telephone interview then recoded into the following categorical variable: low (1-3); medium (4-6); high (7-9)
Job satisfaction	Treated as continuous. The original was scored: 1=extremely satisfied; 2=v satisfied; 3=quite satisfied; 4=quite dissatisfied; 5=v dissatisfied; 6=extremely dissatisfied. This was reverse scored so extremely satisfied=6 to extremely dissatisfied=1
Intent-to-quit	This was treated as a continuous variable with scores ranging between 2 to 8. Lower scores indicated lower intent-to-quit and higher scores indicated higher intent-to-quit
Job demands	As in Chapter 4, Box 4.1
Skill discretion	As in Chapter 4, Box 4.1
Decision Authority	As in Chapter 4, Box 4.1
Job control (decision latitude)	As in Chapter 4, Box 4.1
Co-worker support	As in Chapter 4, Box 4.1
Supervisory support	As in Chapter 4, Box 4.1
Social support	As in Chapter 4, Box 4.1
All time spent in team	Asked as a binary yes/no variable
Team manager same discipline	Sub-set asked if team manager was the same discipline or not (only applicable to nurses, social workers and occupational therapists). Binary yes/no variable
Net job demands (balance between demands and controls)	This was computed from the arithmetic difference between job controls and job demands, (job demands minus job controls). Larger values indicated a better balance between demands and controls for respondents
Job security	Single item question asking to what extent would they agree that their job security was good (strongly agree and agree were coded together as 1, disagree and strongly disagree were coded together as 0). Binary variable of agree/disagree
Nurse managed by non-nurse	Variable computed from raw variables and a binary variable: yes (nurse managed by nurse); no (nurse managed by non-nurse).
Interaction effect	Variable comprised of caseload size multiplied by professional group of three disciplines (nurse/occupational therapist and social worker). It was a binary of interaction effect present - yes/no

CHAPTER 6: MERGED DATASET

6.1 Introduction

The analyses in the previous two chapters (Chapter 4 and 5) did not examine whether there are differences in job outcomes between respondents working in teams focussing specifically with older people comparing single-disciplinary with multidisciplinary settings. The reason for this is that the overwhelming majority of respondents surveyed as part of the Individual Budgets evaluation (Chapter 4), who worked with older people rather than the other client groups, worked as part of single-disciplinary local authority teams. By contrast, all respondents surveyed in the CMHTsOP dataset (Chapter 5) worked with older people as part of multidisciplinary teams. To address this question the two datasets were merged and comparisons in job outcomes between the two team types are made.

Only those respondents working in care management roles with the older people client group were included from the IBSEN dataset (Chapter 4) and only care coordinators (excluding team managers, consultants and doctors) from the CMHTsOP dataset (Chapter 5). Respondents with psychology as a professional role/qualification were included but their professional group was not recoded into a new variable, unlike nursing, social work, and occupational therapist/other therapist.

This chapter is divided into several sections. Firstly, a description of the merged dataset as a whole and the key variables is provided with descriptive statistics. Secondly, bivariate analyses are detailed, focussing upon team type and discriminating between single agency and multi-agency teams. Tests of association are shown using this team type variable with key personal, team-related characteristics, job satisfaction and Karasek domains. Thirdly, a brief discussion considers just those respondents from the professional group of social workers and examines whether there is any relationship between team type and the outcomes of job satisfaction and Karasek domains.

6.2 Description of sample and key variables

All variables outlined can be found in Box 6.1 at the end of this chapter. Each variable is described in detail and any computations and recodes that were necessary for the merged dataset and analyses are explained. Where variables are identical to those outlined in earlier chapters these will be noted.

Personal and team related variables

This new merged dataset contained 366 cases in total, with respondents all working with older people in a care coordination/care management role. Table 6.1 outlines the key personal characteristics of the respondents and shows the frequencies and valid percentages of these. Results are discussed in the following section and similarities or differences noted.

Age

This variable was merged into a categorical variable. The largest proportion of ages of respondents lay in the 45-54 category with 40.7 per cent and the 35-44 category with 27.0 per cent of responses. Both the categories of 35-44 and 55 plus had roughly similar proportions of responses with 16.4 and 15.6 per cent respectively. There were seven missing values for this variable.

Gender

In the merged dataset 81.4 per cent of respondents were female, with nearly one fifth male (18.5%). There were four missing values.

Employment status

The employment status variable for this merged dataset comprised full time and part-time categories. Three quarters of respondents worked full time (74.6%) and one quarter part-time (25.4%). There were eight missing values for this variable.

Professional group

Respondents' professional group was not recorded in an identical manner in both datasets. In the IBSEN dataset (Chapter 4), professional group was identified by asking what professional qualifications were held (social work, nursing, occupational therapy/other allied therapy professions). In contrast, in the CMHTOP dataset (Chapter 5), professional group was coded based on a job title tick box. In combining these variables, assumptions were made regarding the relationship between qualifications held and the professional group they belonged to.

Social work qualification

An important variable for this merged dataset was whether the respondents had a professional qualification in social work or not. In the IBSEN dataset (Chapter 4) there were very few respondents working in multidisciplinary older people's teams who also had a social work qualification, but in the CMHTsOP staff dataset (Chapter 5) there were many. After merging the datasets, one quarter of respondents had a social work qualification (26.2%) and three quarters did not (73.8%). There were three missing values.

Nursing qualification

Respondents were asked whether they had a nursing professional qualification or not. In this merged dataset approximately one third of respondents had a nursing qualification (34.7%) and two thirds did not (65.3%). There were no missing values for this variable.

Occupational therapist or other therapist background

This variable was created by considering responses to different questions in the two questionnaires. The IBSEN questionnaire (Chapter 4) asked if respondents had an occupational therapist/speech therapy/physiotherapist qualification. For the CMHTsOP staff questionnaire in Chapter 5 the individual categories of 'occupational therapist', 'physiotherapist' and 'other' were combined to create a new variable. For the merged dataset only 10.1 per cent of respondents had an occupational therapist or other therapist

qualification and 89.9 per cent did not. There were no missing values for this variable.

Table 6.2 presents the key team-related characteristics of respondents in this merged dataset and the frequencies and valid percentages of these variables are outlined below.

Employed by NHS or local authority (LA)/other

Respondents were asked if they were employed by the NHS or local authority/other organisation. In this merged dataset those respondents employed by the NHS comprised 43.9 per cent of the sample, and those employed by local authorities or other bodies comprised 56.1 per cent of responses. There were six missing values. This variable is not used in section 6.4 and 6.5. When descriptive analyses were undertaken with this variable cross tabulated with team type, no respondents in the IBSEN dataset were employed by the NHS and 107 were employed by the local authority/other in single agency teams. In the CMHTsOP dataset there were 51 respondents (19.8%) employed by local authorities or other and 202 (78.6%) employed by the NHS. There were significant differences between respondents working in single versus multi-agency teams in relation to this variable but these will have been confounded by differences in the two datasets.

Team type

Respondents were asked if they worked in single agency versus multi-agency teams. There were approximately two thirds of respondents working in multi-agency teams (70.6%) with just less than one third working in single agency teams (29.4%). There were only two missing values for this variable.

Active caseload size

The active caseload size variable was categorical. The highest proportion of respondents had a caseload size of 15-24 cases (35%). The next highest proportion of respondents had a caseload size of less than 15 and then 25-34, with 21.0 and 21.3 per cent of responses respectively. The numbers of

respondents reporting they had higher caseload sizes decreased, with 34-45 and 45 plus accounting for 12.8 and 9.9 per cent of responses respectively. There were 23 missing values for this variable.

Team size

Respondents were asked about the number of staff in the team they worked in. Responses were in one of four categories. The highest proportion of respondents worked in teams of 11-15 staff with 35.6 per cent in this category. The next highest team size was in the 16-20 staff category with 24.3 per cent working in teams of this size. The largest and smallest team sizes of 20 plus and less than ten had 20.3 and 19.8 per cent respectively. There were 12 missing values.

Dataset type

The dataset type was a binary variable indicating whether respondents were from the CMHTsOP or the IBSEN dataset. This is included to show the spread across the two different datasets and this was a newly computed variable. As expected there were proportionally more respondents in the CMHTsOP dataset (65.8%) than in the IBSEN dataset (34.2%). Due to the nature of the variable there could be no missing values as this was computed from the two datasets.

Table 6.1: Respondents' personal characteristics

		n	%
Age	18-24	1	0.3
	25-34	59	16.4
	35-44	97	27.0
	45-54	146	40.7
	55+	56	15.6
	Missing	7	
Gender	Male	67	18.5
	Female	295	81.4
	Missing	4	
Employment status	Full time	267	74.6
	Part-time	91	25.4
	Missing	8	
Social worker background	Yes	95	26.2
	No	268	73.8
	Missing	3	
Nursing background	Yes	127	34.7
	No	239	65.3
	Missing	0	
Occupational therapist or therapist background	Yes	37	10.1
	No	329	89.9
	Missing	0	

Table 6.2: Respondents' team-related characteristics

		n	%
Employed by NHS or local authority (LA)/other	NHS	158	43.9
	LA or other	202	56.1
	Missing	6	
Team type	Single agency only	107	29.4
	Multi-agency team	257	70.6
	Missing	2	
Active caseload size	<15	72	21.0
	15-24	120	35.0
	25-34	73	21.3
	35-44	44	12.8
	45+	34	9.9
	Missing	23	
Team size	<=10	70	19.8
	11-15	126	35.6
	16-20	86	24.3
	21+	72	20.3
	Missing	12	
Dataset type	CMHTOP	241	65.8
	IBSEN	125	34.2
	Missing	N/A	

6.3 Outcome variable

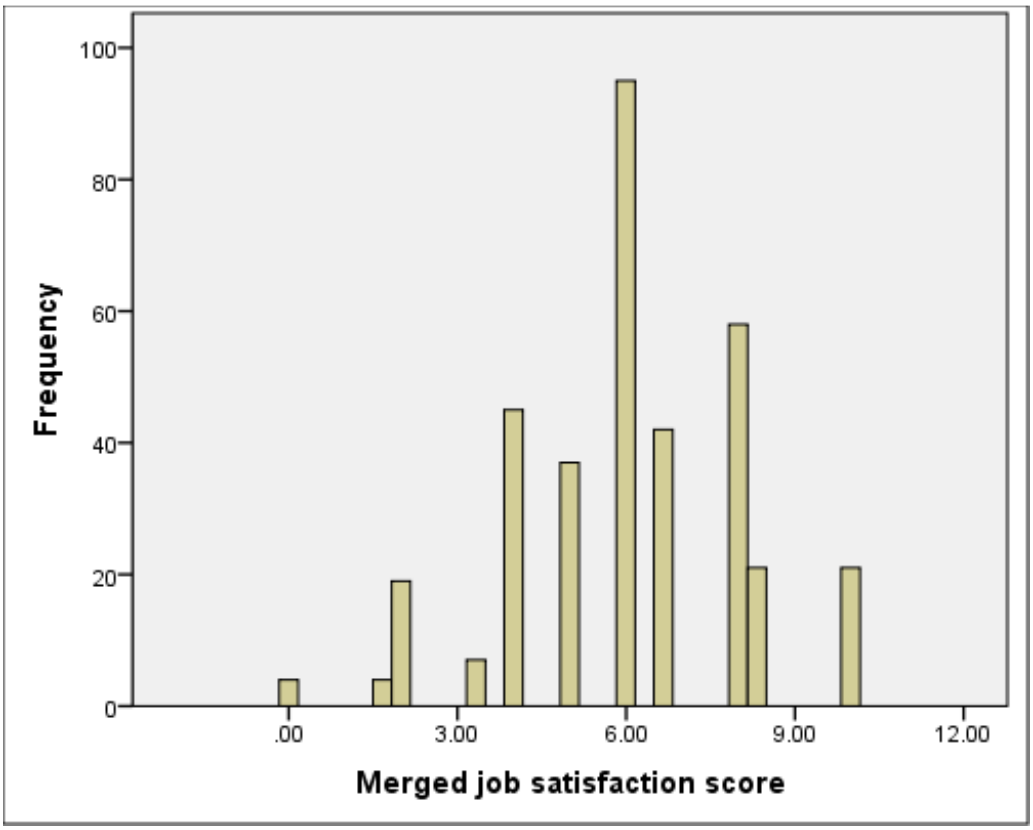
Job satisfaction outcome variable

The key outcome variable of job satisfaction was scored differently in the IBSEN dataset and in the CMHTsOP dataset. In the IBSEN dataset it was scored 1 to 7 and in the CMHTsOP dataset it was scored on a scale of 1 to 6. To accurately merge these two scales together it was decided that these responses should all be transformed onto a new scale of 1 to 10. The lower numbers on the scale would indicate lower satisfaction levels and the higher numbers would show higher job satisfaction levels.

The histogram below (Figure 6.1) shows that the data has some features of a normal distribution with no outliers. The job satisfaction scores are evenly

distributed around the mean of 6.0 with standard deviations of 2.01 either side of this mean peak in the graph. There were 13 missing values for this variable.

Figure 6.1: Merged job satisfaction score



Karasek domains

The frequencies and histograms for the Karasek domains in the merged dataset were very similar to those found in both Chapter 4 and Chapter 5. These do not need to be visually represented in this chapter as the Karasek domains were identical between the two datasets. These variables did not need any additional computations and the Karasek domains will be discussed in section 6.4.

6.4 Bivariate analyses - team type

As the main aim of this thesis is to explore any differences and similarities between team types the analyses in this section were undertaken with a focus upon job satisfaction and Karasek domains. Table 6.3 shows the survey respondents' characteristics, described in the previous section, this time comparing single agency versus multi-agency teams. Chi-squared tests of association were undertaken and significant findings are reported and discussed below.

For the respondents' personal characteristics the significant variables of interest are shown in Table 6.3. A greater proportion of respondents with a professional background in social work worked in single agency teams (59.0%) than in multi-agency teams (36.0%). These differences were statistically significantly (Chi-squared: x^2=67.386, p<0.001). The reverse was found with respondents with a nursing background, those working in multi-agency teams comprised a much higher proportion (46.7%) compared to those with a nursing qualification working in single agency teams (6.5%). This was a statistically significant difference between team types (Chi-squared: x^2=53.610, p<0.001). All other personal characteristics variables in Table 6.3 showed no statistical significant differences between single or multi-agency teams.

With regard to the respondents' team-related characteristics there were significant differences in active caseload size by type of team (Chi-squared: x^2=15.443, p=0.004). There were also significant differences between the differing team size variable categories and type of team (Chi-squared: x^2=14.344, p=0.002).

Table 6.3: Single and multi-agency team type: Personal and team-related characteristics (Chi-squared tests)

		Single agency team	Multi-agency team	x^2 test	p-value
Personal characteristics		%	%		
Age	18-24	0.0	0.0	3.411	0.492
	25-34	20.0	15.0		
	35-44	30.0	26.0		
	45-54	35.0	43.0		
	55+	15.0	16.0		
Gender	%, female	81.9	81.3	0.017	1.000
Employment status	%, full time	74.5	74.6	0.000	1.000
Social worker background	%, Yes social worker	59.0	36.0	67.386	p<0.001
Nursing background	%, Yes nursing	6.5	46.7	53.610	p<0.001
Occupational therapist (OT) or therapist background	%, Yes OT/therapist	11.2	9.7	0.183	0.705
Team-related characteristics					
Active caseload size	<15	30	17	15.443	0.004
	15-24	41	33		
	25-34	17	23		
	35-44	6	16		
	45+	6	12		
Team size	<=10	32	15	14.344	0.002
	11-15	34	36		
	16-20	15	28		
	21+	19	21		

The differences between job satisfaction scores and Karasek variables for respondents working in single and multi-agency teams are shown in Table 6.4 and t-tests of association are also described. The job control variable of decision latitude has been divided into its two component sub-scales of skill discretion and decision authority. The same approach has been employed with the social support variable, which is both summarised as a whole and with its two sub-scales of co-worker and supervisory support. With respect to the job satisfaction scores the sample means are very similar and there are no significant differences between the team types.

For the Karasek domains the skill discretion and social support variables have almost identical means with no significant difference between single and multi-agency team types. With regard to job demands the differences in these means showed slightly higher job demands for respondents working in

multi-agency teams, however this finding was only approaching significance (two-tailed t-test: t=1.718, df=347, p=0.087). With regard to decision authority (sub-scale of job control/decision latitude), respondents reported greater decision authority when they worked in multi-agency rather than single agency teams (two-tailed t-test: t=-2.638, df=351, p=0.009). Those respondents that worked in multi-agency rather than single agency teams also reported greater job control/decision latitude at a statistically significant level (two-tailed t-test: t=-2.699, df=345, p=0.007). Respondents working in social care only teams appeared to have more supervisory support than those in multi-agency teams at a statistically significantly level (two-tailed t-test: t=1.995, df=349, p=0.002).

Table 6.4: Job satisfaction and Karasek domains versus single and multi-agency teams

	Single agency team	Multi-agency team	t value[†]	p-value
	Mean	Mean		
Job satisfaction	6.14	6.00	0.606	0.545
Karasek domains				
Job demands	36.66	35.52	1.718	0.087
Job control/Decision latitude	68.45	71.08	-2.699	0.007
Skill discretion	35.58	36.27	-1.415	0.159
Decision authority	33.10	34.85	-2.638	0.009
Social support	25.86	25.40	1.141	0.255
Co-worker support	13.11	13.14	-0.139	0.890
Supervisor support	12.75	12.21	1.995	0.047

[†]Values based on two-tailed independent t-tests

6.5 Social workers and team types

For the analyses in this section, only data from those respondents who were social workers is considered (n=95). It will be remembered that there were 59 social workers in single agency teams and 36 social workers in multi-agency teams. Throughout Chapters 4 and 5 details of any differences between single and multi-agency teams and key job characteristics of respondents in these datasets have been examined. However in relation to teams working with older people these appear to be predominately single agency teams. This chapter has investigated in detail those respondents working with the client group older people. Here the analyses investigate if professional role impacts upon job outcomes avoiding the potential confounding effect of the presence of several different professionals in a multi-agency team.

Table 6.5: Job satisfaction and Karasek domains versus single and multi-agency teams (social workers only)

	Single agency team	Multi-agency team	t value[†]	p-value
	Mean	Mean		
Job satisfaction	5.85	5.60	0.520	0.605
Karasek domains				
Job demands	37.27	36.91	0.334	0.739
Job control/Decision latitude	68.20	66.56	0.889	0.377
Skill discretion	35.09	35.70	-0.691	0.491
Decision authority	33.36	31.41	1.544	0.126
Social support	25.48	24.50	1.225	0.224
Co-worker support	12.88	12.66	0.568	0.572
Supervisor support	12.60	11.85	1.418	0.160

[†]Values based on two-tailed independent t-tests

As can be seen in section 6.4 of this chapter there are personal and team related significant differences in team types. From the literature review in

Chapter 2 the literature shows that social workers appear more generally dissatisfied than other members of their teams (McLean and Andrew, 2000; Evans et al, 2006). Some analyses were undertaken by the author using only data from social workers who worked in older people's teams. The number of social worker respondents was relatively small with 95 cases, and tests of association can be seen in Table 6.5. These results showed that social workers working with older people had no statistical differences in their job characteristics and job satisfaction scores, whether they were working in a single or multi-agency team. This indicates that the existing literature may overstate differences that the experience of working in multi-agency and single agency teams has for social worker wellbeing. Some of the reported findings about worker wellbeing may be confounded by role blurring and other factors outside of the scope of this thesis. The implications of these results are considered in the following chapter.

6.6 Summary

This chapter has described the combined datasets and presented results of analyses on these solely in relation to respondents that work in older people's teams. Descriptive analyses noted that respondents in multi-agency teams had a lower proportion with a social worker background and more with a nursing background. Respondents also had much higher job controls and poorer supervisory support than those in single agency teams. A further set of analyses just for those respondents with a social work qualification were undertaken, but there were no differences in job satisfaction and job content scores between single and multi-agency teams. The next chapter (Chapter 7) presents a discussion of all these findings and relate these to the literature review in Chapter 2. Limitations and recommendations for future work will be detailed.

Box 6.1: Merged variables in Chapter 6

Variable	How it has been used
Age	For the IBSEN dataset this was originally a continuous variable and was then coded up into categories. The CMHTsOP dataset only asked for ages of respondents in categories. When merging this variable had to be a categorical variable: <35 (less than thirty five); 35-44; 45-54 and 55+ (fifty five and over)
Gender	The gender variable was coded the same for both the IBSEN and the CMHTsOP dataset. Binary categorical variable: 'Female' or 'Male'
Employment status	Both datasets had been recoded into a categorical binary variable so these could be merged into: 'Full time' or 'part-time'
Social work qualification	In the IBSEN dataset respondents were asked if they had a social worker qualification or not. In the CMHTsOP dataset respondents could tick if they had a social worker qualification. Both these were merged together to form a binary variable: 'Yes, social worker qualification' or 'No, social worker qualification'
Nurse qualification	In the IBSEN dataset respondents were asked if they had a nurse qualification or not. In the CMHTsOP dataset respondents could tick if they had a nursing qualification. Both these were merged together to form a binary variable: 'Yes, nurse qualification' or 'No, nurse qualification'
Occupational therapist or therapist qualification	In the IBSEN dataset respondents were asked if they had an occupational therapist (OT)/speech therapy/physiotherapist qualification or not. In the CMHTsOP dataset respondents could tick if they had an 'OT' 'physiotherapist' 'other'. These variables in the CMHTsOP dataset were combined together. Both variables in the dataset were merged together to form a binary variable: 'Yes, OT/therapist qualification' or 'No, OT/therapist qualification'
Employed by NHS or local authority (LA)/other	Both datasets asked this as a binary categorical variable: 'Employed by the NHS' or 'Local authority/other'
Team type	Both datasets asked the same. Binary categorical variable: 'Multi-agency' or 'single agency' team
Caseload size	Categorical variable from both datasets: <15 (less than fifteen); 15-54; 25-34; 35-44; 44+(forty four and over)
Team size	Categorical variable from both datasets: <=10 (less than or equal to ten); 11-15; 16-20 and 21+ (twenty one and over)
Dataset type	Computed categorical variable: 'IBSEN' or CMHTsOP'
Job satisfaction	This was recoded into a 10 item scale as each dataset scored this slightly differently: Now lower numbers equal less satisfaction and higher numbers higher satisfaction: 1=extremely dissatisfied through to 10= extremely satisfied
Job demands	As in Chapter 4, Box 4.1
Skill discretion	As in Chapter 4, Box 4.1
Decision authority	As in Chapter 4, Box 4.1
Job control (decision latitude)	As in Chapter 4, Box 4.1
Co-worker support	As in Chapter 4, Box 4.1
Supervisory support	As in Chapter 4, Box 4.1
Social support	As in Chapter 4, Box 4.1

CHAPTER 7: DISCUSSION

7.1 Introduction

This chapter provides an overview of the findings and how these relate to the research questions and overall aims of this thesis. It briefly outlines these aims and research questions in relation to the background of the topic. The key results are then summarised and limitations of the data collection and methods used throughout the thesis outlined. The implications are discussed in light of the literature review and the findings and policy recommendations detailed. Future research suggestions are also outlined.

7.2 Thesis aims, rational and methods

The main aim of this study was to investigate the determinants of workplace wellbeing and other job outcomes for staff working in Community Mental Health Teams for Older People (CMHTsOP) and social care only teams. This was explored with a focus on multi-agency (high integration) versus single agency (low integration) teams working with older people. The main research questions were investigated using outcome measures of staff wellbeing taken from the following: job satisfaction scores, psychosocial job content questions (Karasek domains of job demands, controls and social support), time use of staff members (IBSEN dataset only); and intent-to-quit scores and qualitative interviews (CMHTsOP dataset only). These were all discussed in relation to whether staff worked in multi-agency or single agency teams and if this hindered or facilitated any of these outcomes. Further details on the aims of this thesis can be found in Chapter 3.

Workplace stress is a key topic of interest and policy relevance. An overwhelming amount of literature, policy documents and initiatives in the last thirty years have been concerned with this and the negative impact it can have on workers' physical and mental wellbeing (Karasek and Theorell, 1990; CIPD, 2005; HSE, 2011). Of particular relevance to this thesis is evidence suggesting that social workers and other mental health

professionals were key disciplines known to be at high risk of workplace stress (Lloyd et al, 2002).

Multi-agency working has been noted in government initiatives as a recommended way of working, particularly in the context of a concern to provide more integrated care (DH, 2001; Royal College of Psychiatry, 2005; DH and CSIP, 2005). Staff working in CMHTsOP, were all, by their very nature, multidisciplinary, whether in higher integration (multi-agency) or lower integration (single agency) teams. By contrast, respondents from the IBSEN dataset could be single discipline (social care only/ therefore single agency teams) or multidisciplinary (health and social care staff/ therefore multi-agency teams).

This research examines the question of whether there is an association between team types: single agency (low integration) or multi-agency (high integration) and respondents' job outcome measures. There are relatively few studies that have considered the impact of team integration in this broader sense and literature has tended to focus more on the narrower aspect of the presence of 'multidisciplinarity'. However several studies do explore integration. One longitudinal study investigated an integrated Mental Health and Social Care Trust and found that reduced job satisfaction and increased stress were present for staff from within the newly formed teams (Gulliver et al, 2003). What was not clear from this study was whether this was due to the new organisational form or to the occurrence of a recent change. In contrast to this, a cross-sectional comparison of community mental healthcare services in four areas in England found respondents in integrated teams reported less role conflict and greater perceptions of team innovation than those in non-integrated teams (Carpenter et al, 2003).

For this thesis a mixed methods approach was employed, utilising both quantitative and qualitative research methods. Further details of the methods used can be found in Chapter 3. The IBSEN dataset involved the secondary analysis of staff questionnaire data obtained from a national study involving the piloting of Individual Budgets in social care in a number of local authority

areas in England (Glendenning et al, 2007). The CMHTsOP dataset detailed the collection and analysis of staff questionnaires and interviews from staff working in these teams. The latter was part of a wider body of work funded by the National Institute for Health Research (NIHR) investigating national trends in service delivery across CMHTsOP (Challis et al, forthcoming). The two quantitative datasets were subsequently combined in Chapter 6 and results from this were considered in relation to comparisons of single versus multi-agency teams working specifically with older people.

7.3 Resume: key findings from the research

This section reviews the overall findings of the thesis, with a summary of key results presented in Box 7.1. The literature review indicated that concern for worker wellbeing and safety has been a key topic over the last 30 years. Workplace wellbeing has been discussed in relation to how higher stress in the workplace can contribute to staff turnover and subsequently staff shortages (Coffey et al, 2004). The consequences of workplace stress upon recruitment and retention have been described in relation to the quality of patient care (Audit Commission, 2002; Poghosyan et al, 2010; Wykes et al, 1997). The review aimed to detail key theories and measures from the wider occupational health literature, including the Job Demand / Control model (Karasek, 1979) and the social support buffer effect (Johnson and Hall, 1998) used in this thesis. A causal model was devised from all the available literature to illustrate key determinants in workplace wellbeing for health and social care staff. The empirical literature demonstrated limited evidence regarding staff wellbeing in the health and social care mental health field. In particular, very few studies were identified that measured the wellbeing of staff working in older people's teams. The majority of studies that were included had limitations mainly arising from small sample sizes and low response rates impairing data analysis. Furthermore, different outcome measures were observed across the differing studies, thereby impairing comparison and synthesising conclusion. It is noteworthy that the majority of

literature in this review used only qualitative interviews for staff views, and thus a key strength of this thesis is the mixed methods approach undertaken.

Box 7.1 Summary of key findings

There is a research gap relating to the consequences of multi-agency working in old age services;

Analysis of job content, satisfaction and time use amongst care coordinators in social care services revealed that respondents in multi-agency (versus single agency teams) reported:

- More time spent in direct contact with service users and less time in contact with other services
- Greater job control
- Poorer supervision
- No difference in overall job satisfaction

Analysis of data relating to CMHTsOP practitioners found that respondents in more integrated teams reported:

- Greater intent-to-quit scores
- A greater imbalance between job demands and controls, although these became statistically insignificant when controlling for other variables;
- Inferior job demand/control balance amongst practitioners being managed outside their own profession;

Qualitative data found that practitioners broadly enjoyed working in multi-agency teams, and those in single agency teams reported frustration in accessing social services support from local authority teams;

Findings may have been confounded by differences in team composition and client groups served. Attempts to resolve these by merging datasets were, broadly, inconclusive.

As detailed in Chapter 4 the IBSEN dataset had a relatively low response rate of 29 per cent for the postal survey. This information came from respondents in 13 English local authorities working across a range of relevant service user groups (including older people). Teams for this study could be either multi-agency or single agency. In this dataset single agency teams were social care only services. The dataset was analysed by considering whether working in a multi-agency team versus a single agency team led to differing outcomes in respondent job satisfaction, job demands, controls, support and work content (activity tasks taken from a diary study). Descriptive analyses and tests of association indicated that respondents in multi-agency teams had more contact with service users, which was associated with positive job satisfaction, and less time in contact with other services. Staff in multi-agency teams also reported greater job control but

poorer supervision scores than those in single agency teams, although supervision scores had a large uni-modal peak in the centre of the distribution, suggesting a high degree of commonality. These two effects possible countered each other and no differences in job satisfaction scores were found between the two team types. It is possible that these bivariate analyses may have been confounded since respondents in multi-agency teams were both considerably more likely to have a nurse / therapist background and less likely to work with older people (one of the key limitations of this dataset). The logistic regression model provided a useful tool for exploring these differences further, as it controlled for any confounding effects. When the impact of supervision quality was analysed, results suggested multi-agency working was still strongly linked to poorer supervision and to increased job controls, even when controlling for other factors.

In the CMHTsOP dataset the self-completed postal survey had a much higher response rate of 59 per cent. Respondents were from 38 CMHTsOP in nine mental health trusts across England, and worked solely with older people (this latter factor was a main difference between this dataset and the secondary IBSEN dataset). Teams scoring lower for the nine indicators of integration (Wilberforce et al, 2010) were classed as single agency teams and those scoring higher were classed as multi-agency. The dataset was analysed by investigating whether working in a multi-agency team versus a single agency team led to differing outcomes in respondent job satisfaction, job demands, controls and support and their intent-to-quit (a new outcome measure). A new variable was also created which was the balance between job demands and job controls, based on earlier research findings (Courvoiser and Perneger, 2010). Descriptive analyses and tests of association showed that respondents in multi-agency teams had significantly greater intent-to-quit scores than those in single agency teams and were more likely to face an imbalance between job demands and controls. Problems arose for respondents in multi-agency teams when they were managed by a team leader from a different professional background to their own, but this could

mostly be attributed to professional group and caseload size. Smaller team sizes were reported for multi-agency teams in comparison to single agency teams. Respondents working in multi-agency teams had slightly worse job outcomes and job satisfaction but none of these findings reached significance.

Stepwise regression revealed that the effect of different integration levels was reduced and statistically not significant when controlling for other team features. In particular, much of the apparent integration effect could be explained by staff mix, job insecurity and (amongst nurses) the difficulties of being managed from outside one's own profession. These pose an interesting challenge for the management and supervision of staff as a range of factors need to be taken into consideration in shaping staff wellbeing. The qualitative data also found that amongst single agency teams (those that had a low level or no integration) there were reports of frustration regarding difficulty in accessing social services support. This was not reflected in the quantitative survey. Overall, despite these challenges, the suggested improvement in understanding between professional groups that was reported in multidisciplinary and multi-agency working led to almost unanimous support for this way of working from staff interviews.

For Chapter 6 the two datasets from Chapters 4 and 5 were combined and analysed. This chapter aimed to investigate whether there were differences in job outcomes in multi-agency and single agency teams, with a focus specifically on older people's teams. Only those respondents working in a care management role with older people were included from the IBSEN dataset and only those care coordinators (excluding team managers, consultants and doctors) from the CMHTsOP dataset. When exploring the data with descriptive statistics and tests of association, multi-agency teams had a much lower proportion of staff with a social worker background and a much higher proportion with a nursing background. Those respondents reported that they had much higher job controls than those in single agency teams. As before, respondents working in multi-agency teams had much lower levels of supervisory support compared with those in single agency

teams. A further set of analyses was conducted in this chapter for a smaller group of respondents with a professional social work qualification. The aim was to investigate whether professional role influenced outcomes and job satisfaction levels in single or multi-agency team working. There were no significant differences between job outcomes and satisfaction levels for respondents working in single versus multi-agency teams. However, there were lower numbers in these analyses with only 95 social worker respondents, which imposed limitations on the conclusions.

Overall, it appeared that multidisciplinary working brings its own challenges. Respondents in general do appear to have greater job control when working in these teams but poorer levels of supervisory support. These two factors may interact and lead to the overall lack of difference in job satisfaction between team types. When the balance of demands and controls is considered, respondents working in multi-agency teams tend to have poorer scores, although it is accepted this could be confounded by other variables. The degree of integration and therefore the impact of single or multi-agency teams would appear to bring both rewards and challenges as a work experience. From the qualitative interviews it can be seen that the majority of respondents enjoy working in a multi-agency and multidisciplinary environment, in particular related to the ability of higher integrated teams to facilitate access to social care services. However there are also concerns, especially where team managers and practitioners are from different professional disciplines, which suggests the need for improved peer mentoring and support in multi-agency teams. Further research is needed to aid understanding about how different levels of multi-agency working impact on respondents wellbeing.

7.4 Limitations

Important qualifications should be considered when interpreting results from this thesis. One of the key limitations for both the datasets was variation in response rates to the postal questionnaires. For the IBSEN data the relatively lower response rate of 29 per cent may reflect the specific difficulties associated with data collection following the implementation of Individual Budgets, which was a new policy direction, in the pilot sites and may make the sample unrepresentative. However, the original authors compared the sample characteristics for pilot sites against national data and concluded that the sample was reasonably representative overall (Wilberforce et al, 2012). For the CMHTsOP dataset, whilst the survey achieved a reasonable response rate (a recent review noted that many staff surveys did not exceed 50 per cent (Onyett, 2011)), it was possible that non-respondents may have differed from respondents. A second limitation for the present study arising from the nature of the IBSEN dataset was that the majority of respondents working in multi-agency teams did not work with older people. This was addressed by merging the IBSEN and CMHTsOP datasets, as discussed in Chapter 6, so as to ensure that a sample of sufficient numbers of staff working with older people could be obtained.

The CMHTsOP dataset was restricted to CMHTsOP respondents from nine Mental Health Trusts and was undertaken at a time of considerable organisational upheaval associated with concerns over public sector finances. This team restructuring, despite occurring widely throughout the NHS and local authorities (Coffey et al, 2004; Edwards et al, 2000) was a key limitation. It was possible that highly integrated (multi-agency) teams, with social worker team members who were employed by local authorities with acute financial restrictions, may have felt greater instability than lower integrated (single agency) teams, due to the particular reductions in local authority funding. In this context, it was seen that local authorities might retreat towards core services and reduce outposting of staff in multidisciplinary teams. Another possible limitation was both conceptual and empirical, namely the measure of integration (outlined in Chapter 3) based on

a simple count of the presence or absence of certain team features. This was not a unique approach and reflected earlier research (Carpenter et al, 2003), however the content of the measure could possibly be open to debate.

Additionally, in neither dataset was stress measured directly, due to space constraints within the postal questionnaire. It relied instead on measures of job satisfaction, job content scores (job demands, control and support), activity time distribution (IBSEN only), intent-to-quit results and the balance between job demands and controls (CMHTsOP). This latter measure of balance has been consistently correlated with stress and burnout in earlier studies (Lloyd et al, 2002; Onyett, 2011). It could be argued therefore that stress is inferred rather than measured in its own right, and the extent to which the other factors contribute to stress assumed. Ideally, it would have been instructive to establish a model whereby stress was both a product of the work environment and also a contributor to a final outcome indicator such as quality of care and, using multivariate methods, estimate the relative effect of the other factors upon this. A possible such model is developed in the next section. Furthermore, the JCQ has not been fully validated among health and social care practitioners, although its widespread use across occupation and geographical boundaries suggests it can be used with confidence. In addition, again due to space and time constraints, the qualitative data utilised for the CMHTsOP study, did not include the views of team managers or consultants, important team actors who may have held alternative views.

One overall limitation of the analyses in Chapters 4, 5 and 6 is that there are many variables that may have an impact on respondent's job characteristics and outcome measures. Firstly, single (low integration) versus multi-agency (high integration) team type were considered. Secondly, the effects of professional group were considered and thirdly, the client group with whom respondents work (in particular older people). These three key variables and possible interactions between them have been discussed in part throughout this thesis and the main aim of the merged dataset in Chapter 6 was to explore these further. However, problems associated with collinearity may

have occurred, with interactions between these variables possibly impacting on respondents' measured outcomes. As noted by Field (2005) multicollinearity can limit the size of the R^2 statistic, and these possible effects are important to consider. It is noted in the future research section of this chapter that the precise measurement of these variables and any possible associated issues are important factors to consider in the design stage of any future research.

7.5 Implications of this research

Current policy and practice guidelines assume that there are significant benefits associated with integrated working practices. As highlighted in Chapter 1 it is argued that improved working relations between health and social care agencies bring increased efficiencies for organisations and more co-ordinated service delivery for service users. However the literature review reported in Chapter 2 found that the implications of multi-agency working for practitioner welfare, and for the effective operation of teams, were mixed. As noted above, the reliance on qualitative methods in specific services and with small sample sizes has prevented generalisable findings from being drawn. This is particularly true with respect to older people's teams. This new research has explored the implications of multi-agency working on a range of job and worker outcomes and in doing so it implies the need for an expanded causal model to that presented in Chapter 2 (Figure 2.1). A new framework is therefore proposed to better establish the link between organisational factors, worker wellbeing, worker performance and the service related consequences of these.

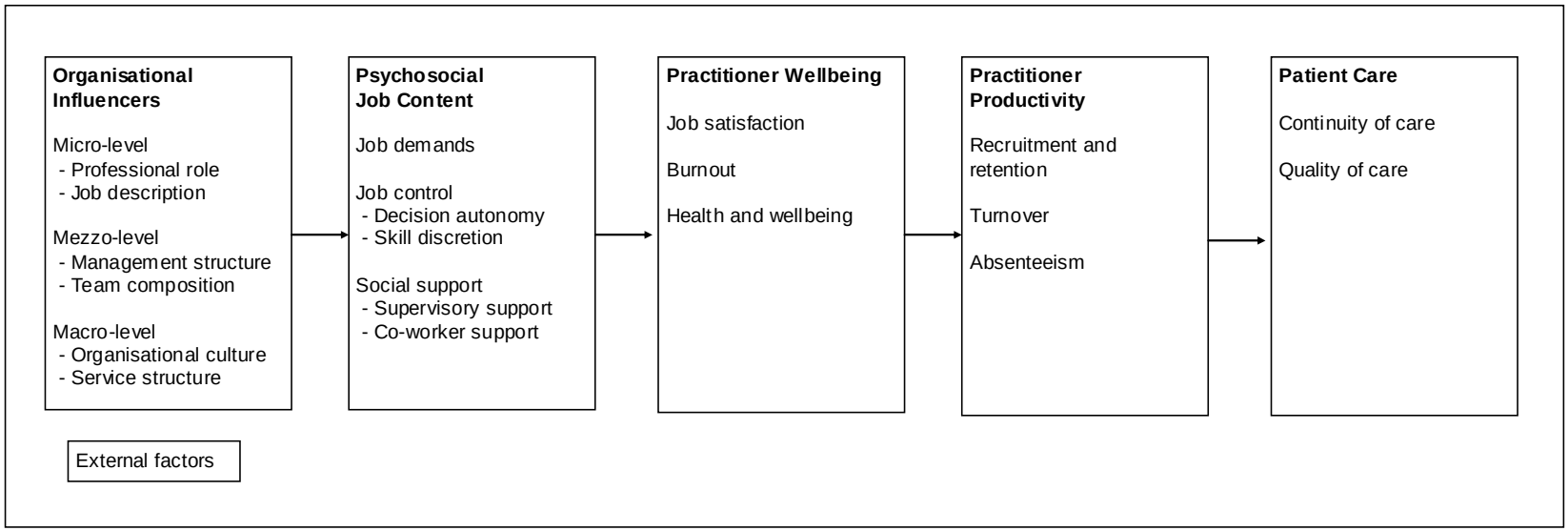
7.6 Revised causal model

As shown in Figure 7.1, the psychosocial job content of work, and consequent personal and patient outcomes, are each influenced by organisational characteristics as a critical antecedent. These link to organisational factors, which are endogenous to the process of shaping

worker wellbeing, worker performance and the service related consequences of these. Figure 7.1 is a revised conceptual model of the set of relationships, developing that in Figure 2.1. The features of this model permit consideration of the complex pathways through organisational arrangements, which can be modified in the short term, through workplace experience and staff performance to the ways in which services are provided and experienced by those who use them.

The principal form of the thesis has been upon the links between box one and two in the model (Figure 7.1). In relation to this, tables 4.9 and 4.10 demonstrated associations between worker type, hours worked and team type with decision authority and supervisory support. Table 5.7 showed an association between degree of integration and intention-to-quit. Table 5.8 showed worker type, length of service and management processes were associated with the balance between demand and control. Hence the revised model, and evidence of the present study, sheds light upon some of the relationships between the elements elaborated in the first four boxes. Clearly further work will be needed to clarify these to a greater extent and develop the important relationship with box five in the model. It would seem that the causal model offers a conceptual and analytic framework superior to that in Figure 2.1.

Figure 7.1: Revised causal model of workplace wellbeing for health and social care practitioners



Organisational Influencers

In this new model, (Figure 7.1) the first box, entitled Organisational Influencers, identify those factors endogenous to or within the control of the organisation are identified. These are the elements which are potentially susceptible to modification so as to subsequently change psychosocial job content, and have later effects upon staff wellbeing, staff performance and ultimately in a human service organisation, the care and support of patients or service users. They are thus endogenous to the model, and are the factors open to change in work settings. It would appear that these can be treated as operating at three different levels. The first, the micro level, deals with factors such as job descriptions for specific roles and professional orientation of individual staff. The second, the mezzo level, addresses factors such as team structure, the ways in which patterns of organisation of units of service delivery, shape staff experience and perception of the possible. The third level, the macro level, is concerned with factors such as organisational culture, or the degree of integration of organisations, such as health and social care, at the upper tiers, leading to developments such as shared budgets. The influence of some of these are factors, such as team type, have been investigated in this thesis. Of course, organisations do not operate in a void but in a context of pressures and constraints, such as levels of demand and available resources, and these external factors are seen as influences which shape the organisational influencers themselves.

From the literature review (Chapter 2), immediate environmental factors were stressors that formed part of the job itself and included staff workload and levels of administration. Most of the problems around high levels of burnout rates were for those staff experiencing more environmental stressors (Evans et al, 2006). This was also the case for community mental health staff where, as workload and administrative duties increased, satisfaction appeared to decrease (Parry-Jones et al, 1998). Elsewhere community mental health staff had higher workloads and administration duties than mental health staff in hospitals and therefore reported lower levels of satisfaction (Prosser et al, 1996). Interestingly, the respondent time activity findings from Chapter 4

may go some way to explaining the role of these environmental factors as it was clear that staff in multi-agency teams had more patient contact and spent less time accessing services than respondents within single agency teams. The qualitative data from the face to face interviews (Chapter 5) also suggested that amongst single agency teams there were reports of frustrations in accessing social services support. Such environmental factors need to be considered in configuring units of organisation and work, such as new team structures and processes, in order to minimise the indirect negative impacts on staff.

Psychosocial job content

The second box in Figure 7.1 is concerned with what Karasek has described as Psychosocial Job Content. This consists of job demands, job control, the balance between the two and support in the workplace. As was noted earlier, taken from the job demand – control (JDC) model of work stress that explores psychological distress, the domain of job demands referred to the degree of pressure placed upon an individual in their job (Karasek, 1979). This may include being asked to do many tasks, unrealistic deadlines, and facing conflicting demands, the latter being a very important factor in an individual's perception of their ability to cope (Parry-Jones et al, 1998). As stress was defined in the literature review as a negative reaction to a set of personal and environmental differences (Cox et al, 2006, p.2), therefore job demands measure the degree of pressure staff experience and not the individual's often idiosyncratic psychological reaction to these pressures (Wilberforce et al, 2012). Although it was of interest to explore whether there were any differences in job demands between staff working in single versus multi-agency teams, no significant effect of this were found in any of the datasets. This may be because the analyses have not fully captured significant and important nuances in the differences between different forms of team types and job demands.

A second element of job content is job autonomy, noted as having the potential to mediate the effects of working in high job demand roles. It has

been suggested that the increased levels of job control have a more protective effect upon perception of job demands and therefore stress levels (Karasek, 1979). In this study, increased job control was very strongly correlated with increased job satisfaction. The level of perceived job control in a workplace may be influenced by managers and commissioners. The extent to which this is lacking may have costs to an organisation in terms of the absence of its protective effect, not always identified, where there is greater standardisation and routinisation of the work experience and continuous organisational change (Pollitt, 1995; Hood, 2007). In the present work, staff working in multi-agency teams reported higher levels of job control than respondents working in single agency teams, perhaps indicating greater space and autonomy in these settings. It follows that an important area of interest is the balance between these demands and controls.

From the literature the most important determinant of workplace psychological health was not these individual domains but the balance between job demands and job controls. One hypothesis of the model was that where demands were high and control was low, there was higher risk of physical and mental health ill-health (Karasek, 1979). A second perspective was that when demands were high but control level was also high, such active work can be positive for job satisfaction (Karasek and Theorell, 1990). In the present work it appeared that respondents in multi-agency teams were significantly more likely to face an imbalance between job demands and controls, although when multivariate analyses controlled for other variables these team differences were not significant. Despite this, it would seem that the balance between job demand and job controls offers an important tool for managers to measure and shape staff strain levels within their teams.

A final feature in the psychosocial content box is that of social support. This has been seen as a key buffer in protecting individuals from stress (Weiss, 1974) in a variety of situations. In the present context, it may be linked to informal support from fellow team members and more formal support through the supervisory process. Debates have occurred as to the type of buffer effect provided, based on whether it was co-worker or supervisory support

involved (LaRocca et al, 1980; Pinneau, 1975). Further research expanded the JDC model to also include an extra social support scale (Johnson and Hall, 1988). This model hypothesised that those jobs with high demands, low controls and also low social support would carry the highest risk of mental and physical health problems and this was supported in the literature (Van der Doef and Maes, 1999). Many studies from the literature showed that when social support scores were high this led to positive effects in job satisfaction scores and rates of burnout were lower (Spear et al, 2004; Kim and Stoner, 2008). In the present work, there were no key differences between staff in single and multi-agency teams for the co-worker support variable. The distribution of responses was centred around the midpoint. Unfortunately no other relevant studies offer a basis for further comparison, but this may be an area for future research.

Supervision support results clustered together and this may indicate a degree of uniformity or evidence of standard processes for supervision within the team's organisational structure. Whilst supervision might be seen as a highly personal aspect of work, tailored to reflect individuals' professional backgrounds and caseload mix, it may be, particularly in larger teams that a degree of procedural routinisation has occurred. Unfortunately it is outside the scope of these quantitative findings to determine subtle nuances of meaning in the supervision support scale. However, supervision scores were significantly lower for respondents working in multi-agency teams than single agency teams. One factor which may have impacted on this is whether team managers had a caseload, potentially giving a greater understanding but also decreasing their time available to provide supervision. The professional background of managers also had an influence on the scores for this variable. Style of leadership would also have been a factor of interest but this was not available in the datasets and supervision is an admittedly weak proxy for this. The presence of discernible differences in supervision styles in different team types is worthy of further investigation as it has implications for management processes within teams.

Practitioner wellbeing

Finally, and relevant to the third box (Figure 7.1), practitioner wellbeing, a large body of evidence is found throughout the literature about the role of social workers and role ambiguity. Social workers and particularly mental health social workers appear to be at a higher risk of lower job satisfaction scores and poorer control over their jobs, leading to greater stress (McLean and Andrew, 2000). The social worker role has changed dramatically and more social workers appear to be finding a marked dissonance between their professional studies and actually practising in teams (Lloyd et al, 2002; Lymbery, 2006; Reid et al, 1998). Where mental health social workers felt undervalued at work and experienced high job demands and low controls they scored much lower on job satisfaction scores (Evans et al, 2006). Other respondents from different disciplines in multi-agency settings have reported that where role conflict is high they have greater levels of burnout and lower job satisfaction scores (Um and Harrison, 1998). In this study the role of social workers working in mental health teams for older people was investigated to discern whether there were any differences between respondents working in single versus multi-agency teams. There were no significant differences between these team types in the job satisfaction scores. There were also no differences between job demands, controls and support scores for social workers in these different settings. This was the final section in Chapter 6, and with only 95 social worker cases, the small numbers may explain the lack of significant findings. Further analyses on role blurring, particularly in relation to social workers, were unfortunately outside the scope of this work.

Practitioner productivity and patient care

These latter two boxes in the model (Figure 7.1) represent the outcomes of the work environment. Productivity relates to classic measures of workplace satisfaction such as recruitment and retention of staff, turnover and absenteeism. Clearly the greater the difficulty in recruiting and retaining staff and the higher the levels of turnover and absenteeism, the poorer the

capacity of the organisation to provide high quality care. This is the content of the last box in the model, the final outcomes of the process, concerned with patient care. A lack of continuity of care and a less content workforce will militate against providing good quality of care.

7.7 Future research work

The model outlined in Figure 7.1 provides a basis for further research that could improve the evidence gap surrounding staff wellbeing and performance in health and social care teams, particularly regarding older people's teams and the benefits of single and multi-agency working. Many factors were outside the scope of this thesis, due to questionnaire space constraints and the use of a secondary dataset (IBSEN) which meant additional variables of interest could not be employed. The measurement of variables and possible associated issues of collinearity are important factors to consider in the design stage of any future research. As seen in the original causal model of the key determinants of workplace wellbeing (Figure 2.1) and the new one developed in the study (Figure 7.1), only job satisfaction was measured within the results as a key practitioner wellbeing measure. Further research could include data that collected respondent's scores on the Maslach Burnout Inventory (Maslach and Jackson, 1981) and possibly other measures of stress related job outcomes. Organisational measures of practitioner productivity and patient outcomes were not collected for this thesis and it would be interesting to explore these in future work to better inform policy and practice recommendations.

Another area for future research could be to examine the role of the mental health social worker working within older people's teams and if there were differences for these staff working in single versus multi-agency teams. Replicating the analyses from the merged dataset (Chapter 6) with more social workers might yield more statistically robust evidence relating to job satisfaction and job content, and also including the measure of the balance between job demands and controls. Including data from social workers on

role ambiguity and role conflict (Rizzo et al, 1970) could also be a further area of interest for future research.

7.8 Conclusion

Overall findings from this study contribute to an improved understanding of the key determinants of workplace wellbeing for health and social care staff in different team settings, and this discussion suggests many fruitful avenues for future research in this area. The author has designed a new causal model of workplace wellbeing and this is a key finding from this thesis. Further work is recommended to investigate this in more detail and add to this area of research. This area of work has very real relevance to both managers and commissioners, since it begins to identify the endogenous (open to modification or change) factors by which work experience in teams may be shaped, and how workforce strategies could address issues of recruitment, retention and performance.

References

Abendstern, M., Harrington, V., Brand, C., Tucker, S., Wilberforce, M. and Challis, D. (2012) Variations in structures, processes and outcomes of community mental health teams for older people: A systematic review of the literature. *Aging and Mental Health*, 16(7), pp. 861-873.

Acker, G.M. (2003). Role conflict and ambiguity: Do they predict burnout among mental health service providers? *Social Work in Mental Health* 1(3), pp. 63-80.

Aiken, L,H., Clarke, S,P., Sloane, D,M., Sochalski, J. and Silber, J,H. (2002) Hospital nurse staffing and patient mortality, Nurse burnout and job dissatisfaction. *Journal of American Medical Association,* 288(16), pp. 1987-1993.

Andrews, F.M. and Withey, S.B. (1976). Social indicators of wellbeing. New York: Plenun Press.

Audit Commission (2002) Recruitment and retention. A public service workforce for the twenty-first century, London: Audit Commission.

Balloch, S., Pahl, J. and McLean, J. (1998) Working in the social services: Job satisfaction, stress and violence. *British Journal of Social Work,* 28*,* pp. 329-350.

Banton, M. (1965). Roles: An introduction to the study of social relations. New York: Basic Books.

Beven, R.G. and Hood, C. (2006) What's measured is what matters: targets and gaming in healthcare in the English public health care systems. *Public Administration*, 84(3), pp. 517-538.

Blaug, R., Kenyon, A. and Lekhi, R. (2007) Stress at Work. [Online] Available at:http://www.theworkfoundation.com/DownloadPublication/Report/69_69_stress_at_work.pdf [Accessed on 27 November 2013]

Bliese, P,D. and Castro, C,A. (2000) Role clarity, work overload and organizational support: Multilevel evidence of the importance of support. *Work and Stress*, 14(1), pp. 65-73.

Borland, J. (1981) Burnout among workers and administrators. *Health and Social Work,* 6*,* pp. 73-78.

Buttrieg, S,. West, M. and Dawson, J. (2011) Well-structured teams and the buffering of hospital employees from stress. *Health Services Management Research*, 24, pp. 203-212.

Cameron, A*.* and Lart, R. *(*2003*)* Factors promoting and obstacles hindering joint working: a systematic review of the research evidence*. Journal of Integrated Care*, 11, pp. 9-17.

Carpenter, J., Schneider, J., Brandon, T. and Wooff, D. (2003) Working in multidisciplinary community mental health teams: the impact on social workers and health professionals of integrated mental health care. *British Journal of Social Work*, 33, pp. 1081-1103.

Caverley, N., Cunningham, J.B. and MacGregor, J.N. (2007) Sickness preventeeism, sickness absenteeism, and health following restructuring in a public service organisation. *Journal of Management Studies*, 44(2), pp. 304-319.

Challis, D., Hughes, J., Jacobs, S., Stewart, K. and Weiner, K. (2007) Are different forms of care-management for older people in England associated with variations in case-mix, service use and care-managers' use of time? *Ageing and Society*, 27(1), pp. 25-48.

Challis, D., Clarkson, P., Hughes, J., Thom, G. and Prabhaker, M. (2011) Evaluation of the Adult Common Assessment Framework Demonstrator Programme Interim Report. Discussion Paper, M266. University of Manchester: Personal Social Services Research Unit.

Challis, D., Tucker, S., Wilberforce, M., Brand, C., Abendstern, M., Stewart, K. et al. National Trends and Local Delivery in Old Age Mental Health Services: Towards an Evidence Base. *NIHR Journal Series [Forthcoming]*

Chartered Institute of Personnel and Development (2005) Absence Management Report. [Online] Available at: http://www.cipd.co.uk/hr-resources/survey-reports/absence-management-2011.aspx [Accessed on 27 November 2013]

Coffey, M., Dugdill, L. and Tattersall, A. (2004) Stress in Social Services: Mental Wellbeing, Constraints and Job Satisfaction. *British Journal of Social Work*. 34, pp. 735-746.

Collins, S. (2008) Statutory Social Workers: Stress, Job Satisfaction, Coping, Social Support and Individual Differences. *British Journal of Social Work*, 38(6), pp. 1173-1193.

Courvoisier, D. S. and Perneger, T.V. (2009) Validation of alternative formulations of job strain. *Journal of Occupational Health*, 52, pp. 5-13.

Cox, T. (1993) Stress research and stress management: Putting theory into practise. Sudbury: HSE Books.

Cox, T. and Griffiths, A.J. (2000) Work-Related Stress. A Theoretical Perspective. In Leka, S. and Houdmont, J. (Eds), Occupational Health Psychology. Oxford: Wiley-Blackwell, pp. 31-56.

Cox, T. and Griffiths, A.J. and Gonzalez, R. (2000) Research on work-related stress. Luxembourg: Office of the Official Publications of the European Communities.

Cox, T., Griffiths, A.J. and Houdmont, J. (2006) Defining a case of work-related stress. Sudbury: HSE Books.

Davis, R,C. (1951) Fundamentals of Top Management. New York: Harper.

Department of Health (1989) Caring for People: Community Care in the Next Decade and Beyond, London: Stationery Office.

Department of Health (1998) Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards, London: Department of Health.

Department of Health (2001) National Service Framework for Older People. London: HMSO.

Department of Health and Care Services Improvement Partnership. Everybody's Business (2005). Integrated mental health services for older adults: A service development guide. London: Department of Health.

Dillon, C. (1990) Managing stress in health social work roles today. *Social Work in Health Care*, 14, pp. 91-108.

Dunleavy, P. and Hood, C. (1994) From Old Public Administration to New Public Management. *Public Money and Management*, 14(3), pp. 9-16.

Edwards, D., Burnard, P., Coyle, D., Fothergill, A. and Hannigan, B. (2000) Stress and burnout in community mental health nursing: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 7, pp. 7-14.

Employment Organisation (2000) *Social Services, Sickness Absence Survey* 1998/99, London: Employers Organisation.

European Agency for Safety and Health at Work, EASHW (2009) OSH in figures: stress at work - facts and figures. [Online] Available at:https://osha.europa.eu/en/publications/reports/TE-81-08-478-EN-C_OSH_in_figures_stress_at_work [Accessed on 27 November 2013]

Evans S., Huxley P., Gately C., Webber M., Mears A., Pajak S. et al. (2006) Mental health burnout and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry*, 188, pp. 75-80.

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues,* 30(1), pp. 159-165.

Glasby, J. and Littlechild, R. (2009) Direct payments and personal budgets: Putting personalisation into practice, Bristol: Policy Press.

Glendinning, C. (2003) Breaking down barriers: integrating health and care service for older people in England. *Health Policy*, 65, pp. 139-151.

Glendinning, C., Challis, D., Fernández, J. L., Jones, K., Knapp, M., Manthorpe, J. et al. (2007) Evaluating the individual budget pilot projects. *Journal of Care Services Management*, 1(2), pp. 123-128.

Gulliver, P., Towell, D. and Peck, E. (2003) Staff morale in the merger of mental health and social care organisations in England. *Journal of Psychiatric and Mental Health Nursing*, 10, pp. 101-207.

The Health and Safety at Work etc Act, 1974 (c37) London: HMSO.

Health and Safety Executive (2011) Self-reported work-related illness and workplace injuries in 2008/09: Results from the Labour Force Survey. [Online] Available at: http://www.hse.gov.uk/statistics/lfs/0809/hubresults.htm [Accessed on 27 November 2013]

Himle, D. P., Jayaratne, S. and Thyness, P. (1989) The effects of emotional support on burnout, work stress and mental health among Norwegian and American**.** *Social Workers Journal of Social Service Research*, 13(1) pp. 27-45.

Hood, C. (2007) Public service management by numbers: Why does it vary? Where has it come from? What are the gaps and the puzzles? *Public Money and Management*, 27(2), pp. 95-102.

House, J., McMichael, A., Wells, J., Kaplan, B. and Landerman, L. (1979) Occupational stress and health among factory workers. *Journal of Health and Social Behaviour,* 20, pp. 139-160.

Hughes J. (2001) Occupational therapy in community mental health teams: a continuing dilemma? Role theory offers an explanation. *British Journal of Occupational Therapy,* 64(1), pp. 34-40.

Huxley, P., Evans, S., Gately, C., Webber, M., Mears, A., Pajak, S. et al. (2005) Stress and pressures in mental health social work: The worker speaks. *British Journal of Social Work*, 35, 1063-1079.

Jacobs, S., Hughes, J., Challis, D., Stewart, K. and Weiner, K. (2006) Care managers' time use: Differences between community mental health and older people's services in the United Kingdom. *Care Management Journals*, 7(4), pp. 169-178.

Jacobs, S., Abell, J., Stevens, M., Wilberforce, M., Challis, D., Manthorpe, J. et al. (2013) The personalisation of care services and the early impact on staff activity patterns. *Journal of Social Work*, 13(2), pp. 141-163.

Johnson, J.V. and Hall, E.M. (1988) Job strain, work place social support, and cardiovascular disease: A cross-sectional study of a random sample of the Swedish working population. *American Journal of Public Health*, 78(10), pp. 1336-1342.

Jones, A. (2001) Role of care pathways in changing psychiatric practice: Action research. *Journal of Integrated Care Pathways*, 5, pp. 15-21.

Kahn, R.L., Wolfe, D.M., Quinn, R.P., Snoek, J.D. and Rosenhal, R.A. (1964) Organizational stress: studies in role conflict and ambiguity. New York: Wiley.

Kanner, A,D., Kafry, D. and Pines, A. (1978) Conspicuous in its absence: The lack of positive conditions as a source of stress. *Journal of Human Stress*, 4(4), pp. 33-39.

Karasek, R. (1979) Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative Science Quarterly*, 24(2), pp. 285-308.

Karasek, R. and Theorell, T. (1990) Healthy Work: Stress, Productivity, and the Reconstruction of Working Life, New York: Basic Books.

Karasek, R., Brisson, C., Kawakami, N., Houtman, I. and Bongers, P. (1998) The job content questionnaire: An instrument for internationally comparable assessments of psychosocial job characteristics. *Journal of Occupational Health Psychology,* 3(4) pp. 322-355.

Kim, H. and Stoner, M. (2008) Burnout and turnover intention among social workers: Effects of role stress, job autonomy and social support. *Administration in Social Work*, 32(3), pp. 5-25.

Knapp, M., Hardy, B. and Forder, J. (2001) Commissioning for quality: ten years of social care markets in England. *Journal of Social Policy*, 30(2), pp. 283-306.

LaRocca, J., House, J. and French, J. (1980) Social support, occupational stress and health. *Journal of Health and Social Behaviour*. 21, pp. 202-218.

Liu, C., Spector, P. and Jex, S. (2005) The relation of job control with job strains: A comparison of multiple data sources. *Journal of Occupational and Organizational Psychology,* 78,(3), pp. 325-336.

Lloyd, C., King, R. and Chenoweth, L. (2002) Social work, stress and burnout: A review. *Journal of Mental Health*, 11(3), pp. 255-265.

Lymbery, M. (2006). United we stand? Partnership working in health and social care and the role of social work in services for older people. *British Journal of Social Work***,** 36(7), pp. 1119-1134.

Manthorpe, J., Stevens, M., Rapaport, J., Harris, J., Jacobs, S., Challis, D. et al. (2009) Safeguarding and system change: Early perceptions of the implications for adult protection services of the English Individual Budgets pilots – A qualitative study. *British Journal of Social Work*, 39, pp. 1465-1480.

Marshall, N.L. and Barnett, R.C. (1993) Work-family strains and gains among two-earner couples. *Journal of Community Psychology,* 21, pp. 64-78.

Maslach, C. and Jackson, S.E. (1981) The measurement of experienced burnout. *Journal of Occupational Behaviour,* 2, pp. 99-113.

Maslach, C., Schaufeli, W.B., Leiter, M.P. and Goldberg, J. (2003) Job burnout: new directions in research and intervention. *Current Directions in Psychological Science*, 12, pp. 189-192.

McCrae, N., Prior, S., Silverman, M. and Banerjee, S. (2007) Workplace satisfaction in a mental health service for older adults: An analysis of the effects of setting and professional status. *Archives of Psychiatric Nursing*, 21(1), pp. 17-24.

McLean, J. and Andrew, T. (2000) Commitment, satisfaction, stress and control among social services managers and social workers in the UK. *Administration in Social Work*, 23, pp. 93-117.

Onyett, S., Pillinger, T. and Muijen, M. (1997) Job satisfaction and burnout among members of community mental health teams. *Journal of Mental Health*. 6(1), pp. 55-66.

Onyett, S. (2011) Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health*, 20(2), pp. 198-209.

Parry-Jones, B., Grant, G., McGrath, M., Caldock, K., Ramcharan, P. and Robinson, C.A. (1998) Stress and job satisfaction among social workers, community nurses and community psychiatric nurses: implications for the care management model. *Health and Social Care in the Community* 6(4), pp. 271-285.

Payne, R,L. (1979) Demands, supports, constraints and psychological health. Guildford: IPC Science and Technology Press Limited.

Pinnaeu, S. (1975) Effect of social support on psychological and physiological strain. Doctoral dissertation: University of Michigan.

Poghosyan, L., Clarke, S.P., Finlayson, M. and Aiken, L.H. (2010) Nurse burnout and quality of care: Cross national investigation in six countries. *Research in Nursing and Health,* 33, pp. 288-298.

Pollitt, C. (1995) Justification by works or by faith?: Evaluating the new public management. *Evaluation*, 1(2), pp. 133-154.

Postle, K. (2002) Working 'between the idea and the reality': Ambiguities and tensions in care managers' work. *British Journal of Social Work*, 32, pp. 335-351.

Priest, P., Dunn, C., Hackett, J. and Wills, K. (2011) How can mental healthcare professionals best be supported in working with people who experience significant distress? *Journal of Mental Health*, 20(6), pp. 543-554.

Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P. and Thornicroft, G. (1996) Mental health, burnout and job satisfaction among hospital and community-based mental health staff. *The British Journal of Psychiatry*, 169(3), pp. 334-337.

Rees, P. and Manthorpe, J. (2010) Managers' and staff experiences of adult protection allegations in mental health and learning disability residential services: A qualitative study. *British Journal of Social Work*, 40(2), pp. 513-529.

Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., Thornicroft, P. et al. (1999) Explanations for stress and satisfaction in mental health professionals: a qualitative study. *Society Psychiatry and Psychiatric Epidemiology,* 34, pp. 301-308.

Rice-Oxley, M. (2013) How hard has depression hit cricket? [Online] Available at: http://www.theguardian.com/sport/2013/nov/25/cricket-depression-jonathan-trott-ashes [Accessed on 27 November 2013]

Ritchie, J. and Lewis, J. (2003) Qualitative research practice. A guide for social science students and researchers. London: Sage Publications.

Rizzo, J.R., House, R.J. and Lirtzman, S.I. (1970) Role conflict and ambiguity in complex organizations. *Administrative Science Quarterly*, 15(2), pp. 150-163.

Royal College of Psychiatrists and the National Institute of Mental Health in England (2005) New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts: Final Report. London: Department of Health.

Schutte, N., Toppinnen, S., Kalimo, R. and Schaufeli, W.B. (2000) The factorial validity of the Maslach Burnout Inventory–General survey across occupational groups and nations. *Journal of Occupational and Organizational Psychology,* 73, pp. 53-66.

Siebert, D,C. (2006) Personal and occupational factors in burnout among practicing social workers. *Journal of Social Service Research*, 32(2), pp. 25-44.

Spear, J., Wood, l., Chawla, S., Devis, A. and Nelson, J. (2004) Job satisfaction and burnout in mental health services for older people. *Australasian Psychiatry***,** 12, pp. 58-61.

Streiner, D.L. and Norman, G.R. (2008) Health measurement scales: A practical guide to their development and use. Oxford: University Press.

Stuart, L. (2001) All stressed up and nowhere to go. Guardian, 17 March [Online] Available at: http://www.theguardian.com/theguardian/2001/mar/17/features.jobsmoney9 [Accessed on 27 November 2013]

Symonds, C.P. (1947) Use and abuse of the term flying stress: In air force military, psychological disorders in flying personnel in the Royal Air Force. Investigated during the War, 1939-1945. London: HMSO.

Taylor, B.J. (2006) Risk management paradigms in health and social services for professional decision making on the long-term care of older people. *British Journal of Social Work*, 36(8), pp. 1411-1429.

Tucker, S., Hughes, J., Burns, A. and Challis, D. (2008) The balance of care: Reconfiguring services for older people with mental health problems. *Aging and Mental Health*, 12(1), pp. 81-91.

Um, M.Y. and Harrison, D.F. (1998) Role stressors, burnout, mediators, and job satisfaction: A stress-strain-outcome model and an empirical test. *Social Work Research*, 22(2), pp. 100-115.

Van der Doef, M. and Maes, S. *(*1999*)* The job demand-control (-support) model and psychological wellbeing: A review of 20 years of empirical research*. Work and Stress,* 13, pp. 87-114*.*

Van Sell, M., Brief, A. and Schuler, R. (1981) Role conflict and role ambiguity: Integration of the literature and directions for future research. *Human Relations*, 34, pp. 43-71.

Van Thiel, S. and Leeuw, R. (2002) The performance paradox in the public sector. *Public Performance and Management Review*, 25(3), pp. 267-281.

Von Abendorff, R., Challis, D. and Netten, A. (1994) Staff activity patterns in a community mental health team for older people*. International Journal of Geriatric Psychiatry*, 9(11), pp. 897-906.

Walsh, B., and Walsh, S. (2002) Caseload factors and the psychological wellbeing of community mental health staff. *Journal of Mental Health,* 11(1), pp. 67-78.

Wanous, J.P.,Reichers, A.E. and Hudy, M.J. (1997) Overall job satisfaction: How good are single-item measures? *Journal of Applied Psychology*, 82(2), pp. 247-252.

Warr, P., Cook, J. and Wall, T. (1979) Scales for the measurement of some work attitudes and aspects. *Journal of Occupational Psychology*, 52, pp. 129-148.

Weinberg, A., Williamson, J., Challis, D. and Hughes, J. (2003) What do care managers do? A study of working practice in older peoples' services. *British Journal of Social Work*, 33(7), pp. 901-919.

Weiss, R.S., 1974. The provisions of social relationships. In Rubin, Z. (ed), Doing unto others. New Jersey: Prentice Hall.

Wilberforce, M., Harrington, V., Brand, C., Tucker, S., Abendstern, M. and Challis, D. (2010) Towards integrated community mental health teams for older people in England: progress and new insights. *International Journal of Geriatric Psychiatry*, 26(3), pp. 221-228.

Wilberforce, M., Jacobs, S., Challis, D., Manthorpe, J., Stevens, M., Jasper, R. et al. (2012). Revisiting the causes of stress in social work: sources of job demands, control and support in personalised adult social care. *British Journal of Social Work.* Advance access 2012: DOI:10.1093/bjsw/bcs166.

Wistow, G., Knapp, M., Hardy, B., Forder, J., Kendall, J. and Manning, R. (1996) Social care markets: Progress and prospects. Philadelphia: Open University Press.

Wood, S., Stride, C., Threapleton, K., Wearn, E., Nolan, F., Osborn, D. et al. (2011) Demands, control, supportive relationships and wellbeing amongst British mental health workers. *Society of Psychiatry and Psychiatry Epidemiology,* 46, pp. 1055-1068.

Wykes, T., Stevens, W. and Everitt, B. (1997) Stress in community care teams: will it affect the sustainability of community care? *Social Psychiatry and Psychiatric Epidemiology*, 32, pp. 398-407.

Appendices

Appendix 1: IBSEN questionnaire (source, Glendinning et al, 2007)

I.D.
/
(for office use only)

ibsen Individual Budgets Evaluation Network

Thank you for agreeing to take part in this study. Individual Budgets are a new approach to organising services which is being tried out in a number of areas across the country. The Department of Health has funded this evaluation of Individual Budgets in order to find out whether this new approach is a good one.

It is important to the evaluation that we look at the impact this new approach has on the care managers and other frontline workers in local authorities. To do this we will not only be speaking to a number of you in each site but we would also like to get as many of you as possible to provide the information set out in this booklet. Your involvement will be valuable, *whether or not you are involved in providing Individual Budgets to service users.*

This booklet comes in three parts: a short questionnaire about yourself; a questionnaire asking for your views on your work environment (the 'Karasek Job Content Questionnaire'); and a one week diary sheet.

The initial questionnaire
We would like you to complete this brief questionnaire about yourself. **Please be assured that this information will not be used to identify individuals and will be treated confidentially within the evaluation team.** It is important for us to collect this information so that the subsequent data on work content and time use will be useful to the evaluation.

The Karasek Job Content Questionnaire
This questionnaire has been widely used to look at aspects of different professionals' working environments. It asks about how you feel about the type of work you do, your job security, the support you have in your job, your relationship to your clients and your self identity through work. It is easily completed, allowing a "tick-box" approach for you to indicate how far you agree with a given set of statements.

The diary study
The final part of this booklet relates to the diary study of frontline workers time use. The format has been developed by researchers at the University of Manchester and has already been successfully used to understand the ways in which working patterns changed after the introduction of care management in the 1990s.

We believe that the diary study is an important tool to help capture some of the differences in the way in which frontline workers organise their working week since the introduction of Individual Budgets. Your assistance in this by completing the diary for a week is very much appreciated. Guidance notes for completion are on the back page of the booklet and the diary and details of the activity types are on the inside back pages.

Feedback
At the end of the study we will send you a summary report of the findings from this part of the evaluation via the IB project lead in your authority. If you would like a certificate that you can use for continuing professional development, please contact us (details on back).

Thank you in anticipation for your assistance with this part of the evaluation. We hope you will enjoy taking part and making such a valuable contribution.

Please complete this short questionnaire about you and your job.
This information will not be used to identify you in any way but is necessary to make full use of the other information you have provided.

1. Age: _____ years 2. Gender: ☐ M ☐ F *(please tick)*

3. Do you have a professional social work qualification? ☐ yes ☐ no *(please tick)*
   If yes, for how many years have you been qualified? _____ years

4. Do you have any other professional qualification? ☐ yes ☐ no *(please tick)*
   If yes, please specify:_____
   If yes, for how many years have you been qualified? _____ years

5. For how long have you been with your current employer?_____ years_____ months

6. Are you ☐ full time or ☐ part time? *(please tick)*
   If part-time, please specify number of contracted hours:_____ per week

7. Where are you usually based? *(please tick)*
   ☐ Local authority social care offices
   ☐ NHS hospital setting
   ☐ NHS general practice setting
   ☐ Other NHS setting
   ☐ Other

8. Are you employed by ☐ the local authority *or* ☐ the NHS? *(please tick)*

9. To which type of team do you belong?
   ☐ Social care professionals only
   ☐ Both health and social care professionals

10. How many members are there in your team in total? _____ *(please insert number)*

11. Which user group(s) do you currently work with?
   ☐ Older people
   ☐ Physically disabled adults
   ☐ Adults with learning disabilities
   ☐ Adults with mental health problems
   ☐ Other
   please specify _____

12. Is your team involved in delivering Individual Budgets to service users? ☐ yes ☐ no *(please tick)*

13. What is your current active caseload size? _____ *(please insert number)*

14. How many of these clients currently receive
   _____ Individual Budgets
   _____ Direct Payments
   _____ Standard services?
   (please insert numbers)

15. How do you feel about your current job? *(please circle one number)*

1	2	3	4	5	6	7
Delighted	Pleased	Mostly satisfied	Mixed (about equally satisfied and dissatisfied)	Mostly dissatisfied	Unhappy	Terrible

The following questionnaire relates to how you feel about your work environment.

Instructions:	Please answer each question by circling the one answer that best fits your job situation. Sometimes none of the answers fits exactly. Please choose the answer that comes closest.			
1. My job requires that I learn new things	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
2. My job involves a lot of repetitive work	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
3. My job requires me to be creative	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
4. My job allows me to make a lot of decisions on my own	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
5. My job requires a high level of skill	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
6. On my job, I have very little freedom to decide how I do my job	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
7. I get to do a variety of different things on my job	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
8. I have a lot to say about what happens in my job	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
9. I have an opportunity to develop my own special abilities	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
10. My job requires working very fast	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
11. My job requires working very hard	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
12. I am not asked to do an excessive amount of work	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
13. I have enough time to get the job done	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
14. I am free from conflicting demands that others make	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)

Instructions:	Please answer each question by circling the <u>one</u> answer that best fits your job situation. Sometimes none of the answers fits exactly. Please choose the answer that comes closest.				
15. How steady is your work?	regular and steady (1)	seasonal (4)	frequent layoffs (4)	both seasonal and frequent layoffs (4)	other (9)
16. My job security is good	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
17. During the past year, how often were you in a situation where you faced job loss or layoff?	never (1)	faced the possibility once (2)	faced the possibility more than once (3)	constantly (4)	actually laid off (5)
18. Sometimes people permanently lose jobs they want to keep. How likely is it that during the next couple of years you will lose your present job with your employer?	not at all likely (1)	not too likely (2)	somewhat likely (3)	very likely (4)	
19. My prospects for career development and promotions are good	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
20. In five years, my skills will still be valuable	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
21. My supervisor is concerned about the welfare of those under him	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
22. My supervisor pays attention to what I am saying	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
23. My supervisor is helpful in getting the job done	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
24. My supervisor is successful in getting people to work together	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
25. People I work with are competent in doing their jobs	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
26. People I work with take a personal interest in me	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
27. People I work with are friendly	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	
28. People I work with are helpful in getting the job done	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)	

Instructions:	Please answer each question by circling the one answer that best fits your job situation. Sometimes none of the answers fits exactly. Please choose the answer that comes closest.			
29. I often get information/feedback one way or another about how the service users or clients feel about the service I provide	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
30. I often get to know clients or service users as individuals on my job	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
31. One way or another, service users or clients can influence the kind of service I provide	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
32. I can affect what the clients or service users want	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
33. Satisfying the service user provides me with an important source of challenges on the job	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
34. I am subject to hostility or abuse from clients/service users	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
35. My knowledge about the client's satisfaction is a major source of my feelings of being important and valuable on the job	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
36. My work group or team makes an important contribution to society	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
37. I am appropriately respected and rewarded by my local authority for my work	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
38. My skills and abilities are "vital" to my work group or team	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
39. I get information/feedback from my supervisor about how well I do my job	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
40. I provide a whole or identifiable service in my job – that is, I can easily point out my contribution to the final service	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)

Source: Karasek, R. (1979) Job demands, job decision latitude and mental strain: implications for job redesign. *Adminstrative Quarterly,* **24**, 285-308.

Please check the activity type first and then insert the code number of the task which occupied the largest amount of time in each half hour slot.

Approved Social Workers only: *If undertaking ASW duties select from section F only. For all other work select from categories A to E.*

Activity Type	Task Category
A. Direct contact with service user	
	1. Pre-assessment information gathering
	2. Interview service user as part of assessment process
	3. Complete relevant social service forms with service user
	4. SSD financial assessment in relation to charging arrangements
	5. Completion of benefit/financial forms, e.g. attendance allowance
	6. Counselling, advising or assisting service user with decision making (include treatment)
	7. Discuss care plan/support plan options
	8. Accompany service user/carer for appointments, e.g. hospital, viewing care home
	9. Adding information to assessment by further telephone contact with user
	10. Review – in person (include check-up visit)
	11. Review – on the phone
	12. Service user related travel, e.g. home visits
B. Direct contact with informal carer	
	13. Gathering information on service user for first assessment from carer
	14. Assessing carer's own needs and completing relevant forms
	15. Providing advice/support for carer
	16. Carer related travel
C. Service contact – user/informal carer related	
	17. Information exchange - multidisciplinary team
	18. Assessment - information gathering from health services staff
	19. Assessment - information gathering from other agencies
	20. Gathering information from existing user records/discuss cases with other social services staff
	21. Complete assessment documentation about service user/carer
	22. Other office-based paperwork, e.g. preparing documentation for panel
	23. Discuss cases in supervision with team leader/manager
	24. Negotiating with and arranging social services for user/carer, e.g. home-care providers, residential/nursing home placement, respite care
	25. Negotiating with and arranging health services for user, e.g. GP, community nurse, hospital
	26. Monitoring **social** service provision, i.e. to ensure appropriate care
	27. Monitoring **health** service provision, i.e. to ensure appropriate care
	28. Review in conjunction with other providers and agencies involved
	29. Travel, i.e. to and from meetings with other agencies
D. Social Services Department	
	30. Administration and reading of departmental documents
	31. Team meeting
	32. Involvement in developing new services or changing existing services.
	33. Training
	34. Dealing with general telephone queries
E. Other	35. Filing, faxing, photocopying
	36. Lunch/breaks
	37. Travel not covered above
	38. Other (include negative visit)
F. ASW Duties	39. Application for admission to hospital
	40. Report writing e.g. for MHRT
	41. PACE Interviews

Week commencing _____

Mon	Tues	Wed	Thurs	Fri	
					8.00
					8.30
					9.00
					9.30
					10.00
					10.30
					11.00
					11.30
					12.00
					12.30
					1.00
					1.30
					2.00
					2.30
					3.00
					3.30
					4.00
					4.30
					5.00
					5.30
					6.00
					6.30
					7.00

Please indicate with an asterisk any periods for which you were on (office) duty

Please see over for instructions on completion

DIARY STUDY – Guidance for completion

1 Please complete this diary sheet anonymously.

2 Prior to the first day please familiarise yourself with the categorisation.

3 Select a task code number and insert it into the relevant time slot. For example, if completing a financial assessment please insert code 4 into the corresponding half hour in which you did this.

4 Some of the tasks of care management, are reflected in more than one activity type. Assessment and review are two such activities.

5 Life does not fit into neat half hour slots, so indicate the task which occupied most of each time period. If this is not possible please indicate the two tasks which most occupied you during this period.

6 For staff away from work during the week of the diary study, please complete it for the second week after your return. If you are away for part of the week please complete for those days the following week.

7 Complete the diary each day and if possible do this through the day. To leave it until later increases the likelihood of inaccurate information.

8 At the end of the week, return the completed booklet in the envelope provided.

9 If you have any queries please telephone XX on XX or email

Please return this entire booklet in the envelope provided to:

PSSRU
Personal Social Services Research Unit
Dover Street Building
University of Manchester
Oxford Road
Manchester M13 9PL

Appendix 2: CMHTsOP Staff questionnaire

CONFIDENTIAL INFORMATION

COMMUNITY MENTAL HEALTH TEAMS FOR OLDER PEOPLE
A study of different ways of working
STAFF QUESTIONNAIRE

Thank you very much for taking part in this study. Please ensure that you have read the information sheet before completing the questionnaire. Please answer all the questions, and return the questionnaire in the pre-paid envelope. If you have any questions please contact Mark Wilberforce on 0161 275 5391.

PART ONE: YOU AND YOUR JOB

1. What is your role within the team?

- ☐ Team manager
- ☐ Community mental health nurse
- ☐ Social worker
- ☐ Support worker
- ☐ OT
- ☐ Psychologist
- ☐ Consultant psychiatrist
- ☐ Other grade of doctor
- ☐ Physiotherapist
- ☐ Other job title

(please specify_____)

2. How long have you worked in this CMHT? ____ Years ____ Months

3. Are you ☐ Male ☐ Female

4. Are you employed ☐ Full-time ☐ Part-time ☐ Part time job share

5. What is your age? ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55 or over

6a. Is all your work within the CMHT? ☐ Yes ☐ No

6b. *If no, approximately what percentage of your working week is spent on CMHT work?* _____ %

7. Are you employed by ☐ NHS ☐ Local authority ☐ Other

8. What is the size of your current active caseload (please estimate if not known) _____

9. Overall, how satisfied do you feel with your current job? *(please **circle** one number)*

1	2	3	4	5	6
Extremely satisfied	Very satisfied	Quite satisfied	Quite dissatisfied	Very dissatisfied	Extremely dissatisfied

Team ID_____

1

PART TWO: YOUR WORK ENVIRONMENT IN GENERAL

Instructions: Please answer each question by ticking the response that best describes your situation.

	Strongly disagree	Disagree	Agree	Strongly agree
1. My job requires that I learn new things	☐	☐	☐	☐
2. My job involves a lot of repetitive work	☐	☐	☐	☐
3. My job requires me to be creative	☐	☐	☐	☐
4. My job allows me to make a lot of decisions on my own	☐	☐	☐	☐
5. My job requires a high level of skill	☐	☐	☐	☐
6. On my job, I have very little freedom to decide how I do my job	☐	☐	☐	☐
7. I get to do a variety of different things on my job	☐	☐	☐	☐
8. I have a lot of say about what happens in my job	☐	☐	☐	☐
9. I have an opportunity to develop my own special abilities	☐	☐	☐	☐
10. My job requires working very fast	☐	☐	☐	☐
11. My job requires working very hard	☐	☐	☐	☐
12. I am not asked to do an excessive amount of work	☐	☐	☐	☐
13. I have enough time to get the job done	☐	☐	☐	☐
14. I am free from conflicting demands that others make	☐	☐	☐	☐
15. In five years, my skills will still be valuable	☐	☐	☐	☐
16. My line manager is concerned about the welfare of those under him/her	☐	☐	☐	☐
17. My line manager pays attention to what I am saying	☐	☐	☐	☐
18. My line manager is helpful in getting the job done	☐	☐	☐	☐
19. My line manager is successful in getting people to work together	☐	☐	☐	☐
20. People I work with are competent in doing their jobs	☐	☐	☐	☐
21. People I work with take a personal interest in me	☐	☐	☐	☐

Instructions: Please answer each question by ticking the response that best describes your situation.				
	Strongly disagree	Disagree	Agree	Strongly agree
22. People I work with are friendly	☐	☐	☐	☐
23. People I work with are helpful in getting the job done	☐	☐	☐	☐
24. I often get information/feedback one way or another about how the service users/carers feel about the service I provide	☐	☐	☐	☐
25. I often get to know service users/carers as individuals in my job	☐	☐	☐	☐
26. One way or another, service users/carers can influence the kind of service I provide	☐	☐	☐	☐
27. I can affect what the service users/carers want	☐	☐	☐	☐
28. Satisfying the service user/carer provides me with an important source of challenges on the job	☐	☐	☐	☐
29. I am subject to hostility or abuse from service users/carers	☐	☐	☐	☐
30. My knowledge about the client's satisfaction is a major source of my feelings of being important and valuable on the job	☐	☐	☐	☐
31. My team makes an important contribution to society	☐	☐	☐	☐
32. I am appropriately respected and rewarded by my employer for my work	☐	☐	☐	☐
33. My skills and abilities are "vital" to my team	☐	☐	☐	☐
34. I get information/feedback about how well I do my job	☐	☐	☐	☐
35. I provide a whole or identifiable service in my job – that is, I can easily point out my contribution to the final service	☐	☐	☐	☐

PART THREE: ORGANISATIONAL ASPECTS OF YOUR JOB

Instructions: For each statement please rate how satisfied/dissatisfied you feel by ticking the box which best describes your feelings. Please note part A relates to the CMHT and part B to the larger organisation that the CMHT is a part of.

	Extremely satisfied	Very satisfied	Quite satisfied	Quite dissatisfied	Very dissatisfied	Extremely dissatisfied
Part A : In relation to the CMHT how do you feel about:						
1.Communication and the way information flows around your team	☐	☐	☐	☐	☐	☐
2. The extent to which you identify with the public image or goals of your team	☐	☐	☐	☐	☐	☐
3. The way changes and innovations are implemented	☐	☐	☐	☐	☐	☐
4. The amount of participation you are given in important decision making	☐	☐	☐	☐	☐	☐
5. The psychological 'feel' or climate that dominates your team	☐	☐	☐	☐	☐	☐
6. The design or shape of your team's structure	☐	☐	☐	☐	☐	☐
Part B: In relation to the wider organisation how do you feel about:						
7.Communication and the way information flows around your organisation	☐	☐	☐	☐	☐	☐
8. The extent to which you identify with the public image or goals of your organisation	☐	☐	☐	☐	☐	☐
9. The way changes and innovations are implemented	☐	☐	☐	☐	☐	☐
10. The amount of participation you are given in important decision making	☐	☐	☐	☐	☐	☐
11. The psychological 'feel' or climate that dominates your organisation	☐	☐	☐	☐	☐	☐
12. The design or shape of your organisation's structure	☐	☐	☐	☐	☐	☐

PART FOUR: HOW YOUR CMHT WORKS

Instructions: Please answer each question by ticking the response that best describes your situation.

	Strongly disagree	Disagree	Agree	Strongly agree
1. My particular professional expertise is valued by the team	☐	☐	☐	☐
2. Colleagues from other professions within the team have a good understanding of my role	☐	☐	☐	☐
3. I am able to practice as an autonomous professional within the team	☐	☐	☐	☐
4. Work is allocated according to a person's skills rather than professional background	☐	☐	☐	☐
5. We often disagree about which team members should do which tasks	☐	☐	☐	☐
6. My particular professional expertise is used appropriately within the team	☐	☐	☐	☐
7. I am often asked/expected to do things that are outside my professional role	☐	☐	☐	☐
8. Working with other professions has helped me develop new skills	☐	☐	☐	☐
9. I often feel torn between the values and goals of my own profession and those of the team	☐	☐	☐	☐
10. I feel professionally isolated	☐	☐	☐	☐
11. There is an atmosphere of openness and trust within the team	☐	☐	☐	☐
12. We spend time together reflecting on how the team operates	☐	☐	☐	☐
13. I feel that my opinions aren't really listened to	☐	☐	☐	☐
14. Professional differences often get in the way	☐	☐	☐	☐

Instructions: Please answer each question by ticking the response that best describes your situation.				
	Strongly disagree	Disagree	Agree	Strongly agree
15. The opinions of some team members seem to carry more weight than those of others	☐	☐	☐	☐
16. The consultant is no more or less involved in the team than anyone else	☐	☐	☐	☐
17. The consultant should see more service users than he/she does	☐	☐	☐	☐
18. When it comes to clinical decisions, the consultant's view usually takes precedence over other people's	☐	☐	☐	☐
19. The consultant has a strong influence on how the team works/operates generally	☐	☐	☐	☐
20. The consultant has a strong leadership role within the team	☐	☐	☐	☐
21. The consultant sees service users he/she doesn't need to see	☐	☐	☐	☐
22. In the end, its the consultant who takes overall clinical responsibility for the work of the team	☐	☐	☐	☐
23. I can readily access input from a range of disciplines	☐	☐	☐	☐
24. I waste a lot of time trying to access information or services	☐	☐	☐	☐
25. Service user information is shared efficiently within the team	☐	☐	☐	☐
26. The IT system we have in place makes record keeping easy / efficient	☐	☐	☐	☐
27. It is easy to get all the relevant service user information I need in order to do my job	☐	☐	☐	☐
28. The team tends to welcome new ideas	☐	☐	☐	☐

	Strongly disagree	Disagree	Agree	Strongly agree
29. The team is flexible and adaptable	☐	☐	☐	☐
30. The team feels stable	☐	☐	☐	☐
31. My job security is good	☐	☐	☐	☐
32. I am satisfied with my career development prospects in my current job	☐	☐	☐	☐
33. I often think of quitting my current job	☐	☐	☐	☐
34. I am actively looking for a new job	☐	☐	☐	☐
35. Service users get a good service	☐	☐	☐	☐
36. Service users/carers complain about having to repeat the same information to lots of different professionals	☐	☐	☐	☐
37. The care that service users/carers get is too fragmented	☐	☐	☐	☐
38. Service users/carers experience too many delays in getting the services they are entitled to	☐	☐	☐	☐
39. Service users/carers experience a seamless service	☐	☐	☐	☐

Please feel free to add any further comments in this box

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE. PLEASE NOW RETURN IT IN THE PRE-PAID ADDRESSED ENVELOPE SUPPLIED.

Appendix 3: CMHTsOP Qualitative interview schedule

Professional staff member topic group

Part 1: Roles and responsibilities

Professional background and history within the team.		
1	Can you tell me how you came to join the team?	*Probe for –Brief professional history, worked in similar or different (mental health or other) settings in past.*
2	Can you briefly **describe your role**?	
3	How does this **differ /overlap** with others?	*Caseload size and turnover, amount of face-to-face contact, initial assessment*
4	What if any are the advantages of this overlap (or lack of)?	
5	Are you clear about what your role involves and where are its boundaries?	
6	Do you feel that this role is clearly linked to your professional identity and skills? If not, in what way?	
7	Are you asked to do things that are **outside your remit**? Can you give examples?	*(Probe also for tasks with too much / too little responsibility – e.g. initial assessment).*
8	What do the activities that you undertake add to the service provided by the team?	
9	How much **flexibility / autonomy** do you have about how you work?	*Length and intensity of involvement, nature of input? Do you make decisions independently? Take initiative, be creative*
10	Do you think everyone in the team understands your role and uses you/your skills effectively / appropriately?	
11	Do you feel that other team members **value** the contribution your skills can bring?	
12	Are you clear about the roles of other team members? Do you feel that other team members' skills are used effectively?	
13	***If you also have duties outside the team:*** Can you explain how you work with the team alongside your other duties?	

Part 2: Management, supervision and support

14	Who is your employer? Who is your line manager?	*MH Trust / SSD / other NHS sector*
15	What are the formal arrangements for clinical supervision (from whom do you get it)? Are there any issues around this? (particularly if manager and supervisor are different)	*Probe: effect if no supervision available from within profession*
16	Do you have enough contact with your own discipline?	*Is there adequate peer support?*

	Do you identify more strongly with the team or with your own profession?	
17	How do you relate to the others in your profession outside the team?	*Networks? foot in 2 camps or fully joined up to the CMHT?*
18	What informal support networks do you use?	Inside and outside the team.
19	To what extent are you involved in decisions about: 1. Casework issues (allocation/closing cases) 2. Team development issues	*Probe for: seniors, manager only,* *Democratic process meetings etc*
20	Is the role of the team manager/leader clear?	*What gives them their authority?*
21	Do you think that the professional discipline of the team manager makes any difference to the way they can supervise and support staff / the way the team is run/managed?	
22	If manager carries a caseload: What is the impact of having a manager who is also a practitioner? (Advantages/disadvantages)	

Part 3: Integration *(some of this section might already have been covered in discussion of role)*

A: Team level issues		
23	What are the advantages/disadvantages of having the particular range of professionals that you have within the team?	*Probe for:* *How well does it work?* *Communication issues* *Any tensions?*
24	What do you think the impact of having / *not* having social workers in your team is on service users? *Ask for examples*	
25	What happens if you are the CC and the service user needs the input of another professional within/ outside the team?	*Example? Differences in integrated/non-integrated teams*
26	Will you usually be aware of the input to individual service users from other agencies/services? Will they be aware of your input? What is the impact of this for service users?	*Care plans contain all involvement?* *How does this work, e.g. of good and poor practice*
27	**For high integration teams**: If a social worker from outside the team is involved, does the service user get the same service? Does this occur? What is the difference?	
28	**For low-integration teams**: Can you describe the process of referring to social services outside the team?	
29	How does the way in which records are competed and accessed / kept and managed impact on the service you deliver?	*Probe for: IT issues, electronic vs hard-copies.* *Who can access/input?* *Duplication*

B: Agency level issues		
Social services		
30	What is the working relationship like between the team and generic social services older people's teams	Links to named workers, attendance at meetings Formal / informal arrangements
31	Is there a <u>clear demarcation</u> between the work of the CMHT and the local social services older people's team in terms of who should be referred where? <u>*If yes*</u>, can you explain what this is? <u>*If no*</u>, can you describe how this impacts on the team and on service users?	
32	What is the impact of the way you currently work with social services on service users?	
33	What do you think are the obstacles to, and facilitators of, joint working / integration with social services?	<u>*Probe for*</u>*: Are there particular flash points (e.g. hospital discharges) or examples of good practice?*

ASK CPNs ONLY:		
34	Can you describe the process of referring to the psychologist outside the team?	<u>*Probe for:*</u> *service level access agreements* *Age-specific or generic service?*
35	Can you describe the process of referring to the OT outside the team?	How does it work in practice? If there are OTs in the team – what difference does it make?

<u>Part 4: The role of the consultant</u>

36	Can you describe how responsibility for an individual's care is shared between you and the consultant? What do you think about the way in which this responsibility is shared or not?	<u>*Probe for:*</u> *Who takes overall clinical responsibility for cases? Do consultants have any managerial responsibilities?* *Is there a shared understanding of this approach by all team members?*
37	Do you get the appropriate level of support from the consultant/other OAP	Accessible / helpful / supportive What if anything would be better
38	To what extent is the consultant involved with the team on a day-to-day basis?	<u>*Probe for*</u>*: Do they directly manage/supervise anyone in team*
39	What role do other doctors play in the team? How do you relate to them?	

40	How do you regard the consultants that work in your team?	*Equal members / different in some way / seniors?*
41	How would you describe the nature and degree of the consultant's (and other doctors) influence within the team?	
42	What works well in terms of the way the consultant's work is organised?	*<u>Probe for:</u> Community/in-patient split or locality based?* *Involvement in meetings, team development…*
43	What could be better about the way that the consultant's role operates for a) Team members b) Service users	
44	Based on your own experience in mental health services for older people, how has the consultant's role within the team changed over time?	
45	Have changes had any adverse as well as beneficial consequences?	

Part 5: The role of the support worker

46	What is the role of the support worker(s) in your team? Is this clear, do you think? What is their job title?	Is there more than one role/title? What about OTA CMA? Are these similar to each other or more akin to the profession they relate to?
47	What sort of work do they do that is <u>not</u> done by other team members? Do you feel that this is appropriate?	
48	What are the benefits to the team and service users are having this support worker role?	
49	Are there other roles undertaken by qualified staff that could be undertaken by support workers? Examples? Do you perceive any problems in extending role of support workers? *Probe: "specialist" roles, such as dementia home care work;*	

Part 6: Concluding thoughts

50	What are the benefits to the service user (and staff) of the way the work of the team is organised? What are the disadvantages?
51	Would you like to see further integration and if so –what precisely?
52	If yes, to what extent would this affect service user outcomes?
53	What causes you most frustration and stress about the role you play in the CMHT?
54	What do you find most rewarding about the role you play in the CMHT?
55	Is there anything more that you'd like to add / that I have not asked you about? e.g. other changes that have had a impact on the team

Appendix 4: Qualitative data analyses (coding and theme development)

The process of coding and theme development followed a three step approach.

First step

The qualitative interviews were initially undertaken for NIHR-funded research investigating service user outcomes associated with different CMHT models (Challis et al, forthcoming). As part of that study, transcripts were coded according both to themes originating in the topic guide and also emerging within the data. Upon reviewing the coding frame, 11 codes were identified by the thesis author as being salient to contributing to a greater understanding of the relationship between job characteristics and staff wellbeing (shown in Box 1).

Box 1: Eleven codes of interest from the NIHR-funded research interview transcripts

- Control (authority to make decisions/autonomy)
- Control (role expansion)
- Feeling valued
- Frustrations
- Identity
- Links with own profession
- Overlapping roles
- Rewards
- Support worker
- Team climate
- Team manager support and discipline

Second step

All the transcript sections that were coded into these 11 were identified within the 24 interview transcripts using Atlas.ti. Text was extracted, read in full and in addition keyword searches were undertaken on the full interview transcripts for words related to the aims of the thesis, e.g. support, autonomy, control.

Third step

All extracted segments of texts were then reviewed in full, notes were taken and organised into tables describing common emergent themes. Where there was agreement within a section, findings were then drafted under five thematic headings (Box 2) reflecting issues identified both within existing literature and emerging within the analysis. The quotations were selected as best illustrating the key findings across both team types.

Box 2: Themes for analysis

- Job demands on staff (pressures and frustrations)
- Job control (work autonomy)
- Supervision and co-worker support
- Balance between support and control
- Job satisfaction (in relation to the team integration level, support worker and professional identity)