Exploring the relationship between patients' experiences of care and the influence of staff motivation, affect and wellbeing

Annexe: Case studies

Jill Maben,[1] Riccardo Peccei,[2] Mary Adams,[1] Glenn Robert,[1] Alison Richardson,[3] Trevor Murrells[1] and Elizabeth Morrow[1]

[1] National Nursing Research Unit, Department of Health Policy and Management, Florence Nightingale School of Nursing and Midwifery, King's College London
[2] Department of Management, King's College London
[3] Faculty of Health Sciences, University of Southampton

NHS
National Institute for Health Research

Published November 2012

Address for correspondence:
Professor Jill Maben
Director, National Nursing Research Unit,
Florence Nightingale School of Nursing and Midwifery
King's College London, Room 4.29, 4th Floor
James Clerk Maxwell Building
Waterloo Road
London SE1 8WA
Email: jill.maben@kcl.ac.uk

This annexe should be referenced as follows:

Maben J, Peccei R, Adams M, Robert G, Richardson A, Murrells T. and Morrow E. Patients' experiences of care and the influence of staff motivation, affect and wellbeing. Phase II case studies: Annexe to final report. NIHR Service Delivery and Organisation programme; 2012.

Relationship statement:

Copyright information:

Disclaimer:

This report presents independent research funded by the National Institute for Health Research (NIHR). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health. Verbatim quotations included in this publication are the views and opinions expressed by the interviewees and not necessarily those of the NHS, the NIHR or the Department of Health.

Criteria for inclusion:

Reports are published if (1) they have resulted from work for the SDO programme including those submitted post the merge to the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors. The research in this report was commissioned by the SDO programme as project number 08/1819/213. The contractual start date was in July 2008. The final report began editorial review in October 2011 and was accepted for publication in November 2012. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The SDO editorial team have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report documentation. However, they do not accept liability for damages or losses arising from material published in this report.

Contents

Introduction

This annexe to the final report presents further information about the case studies undertaken in Phase II of the study. The following sections provide detail of four (of our eight) microsystems, those not presented in the main report because of limitations of space. These include two acute services; Maternity and Medicine for the Elderly and two community; Community Matron Service and Rapid Response Team.

Oakfield Acute Trust: Maternity Service

Local team climate and professional identity: how healthcare staff support each other to deliver patient-centred care

Summary

This case study was sampled as a high performing microsystem in a low performing Trust. Patients in the maternity microsystem - selected as the high performing microsystem in our 'low performing' Oakfield Acute Trust - were generally satisfied with the care they received. Our qualitative data suggest that midwives were generally seen by patients as being caring and professional, with common reference to 'feeling safe' during the patient interviews. The main patient concerns were related to the physical environment (cleanliness, heating and the general condition of the wards - 'dated and a bit depressing') and the quality of the food; communication between consultants and patients was also viewed as poor in some cases. Patient ratings in our survey on all measures sat typically some way above those of patients from our EAU microsystem in the same Trust but - compared to the 'high performing' Elmwick Trust - slightly below those in M for E and significantly below the haematology service that was rated the highest overall in our study.

The staff survey results produced a clearer distinction between the maternity service and the seven other microsystems we studied. With regard to their self-reported 'patient care performance' maternity staff rated their 'relational performance' more highly than staff in any of the other microsystems and their 'functional' and 'in-role performance' very highly too; staff here, as with our M for E microsystem, self-reported their 'patient care performance' as being higher than that reported by patients themselves. Our analysis of the qualitative data from the maternity service at Oakfield highlighted four themes influencing staff wellbeing and patient experience:

- how satisfied, dedicated and 'positive' staff can shape patient experience, and the implications for their own wellbeing
- the value of mentoring and supervision for establishing a supportive local team climate (and the seeming irrelevance of organisational climate) for patient-centred care
- how job demands can limit staff capacity to give discretionary effort
- the importance of professional identity to staff wellbeing and patient experience

Project 08/1819/213

How satisfied, dedicated and 'positive' staff shape patient experience, and the implications for their own wellbeing

Patients spoke positively about their care ('*all the midwives on the labour ward were very good … the midwife who helped with the delivery, she was absolutely fantastic'* (patient 7); *'really, really helpful. I mean, everyone has just been brilliant, I can't say a bad word about anybody'* (patient 6); *'absolutely brilliant … They're always there when you need something* (patient 5); *'I can't fault it'* (patient 1)) and specifically with regard to the relational aspects of that care ('*just a really nice kind of atmosphere … I could have a little joke and laugh with them, and as I was pushing they'd be laughing with me and what have you. Then it just seems fun, but still professional, and easygoing, and I think that's why it felt so comfortable'* (12-070610)).

Patients specifically highlighted the good communication skills of the midwives who cared for them and the importance to themselves of feeling listened to (patient 7) - '*we did have a midwife in there all the way through, and she was fantastic, talking us through everything all the time, explaining why certain things were being done, or would we like to try this … we were never pushed into anything, which was really nice'* (12581) - and how this *'puts your mind at ease'* (patient 3). The poor physical environment of the maternity service was a problem for some patients but not others ('*the age of the hospital doesn't bother me at all … it doesn't matter so much the rooms and whether it's painted or the rest of it, it's the care at the end of the day* (patient 3)), whereas staff highlighted the environment they worked - and cared for patients - in, more frequently:

> *"It's horrendous [laughs]. As I'm sure you can see, it's a very old building. It has a huge impact on how the staff work. It's either absolutely freezing or it's absolutely boiling. We have no air conditioning. The windows barely open and some of them are so old we can't open them. Depending on the way the wind blows, the windows rattle. I've had mothers that have really been frightened thinking the windows are going to fall in on them and their babies … I mean, things like we don't have enough showers, things like the logistics of the building... It's a very tired building ... When you haven't got enough storage space for all of your equipment, so you have to have things stored in corridors or stored in bathrooms, which isn't ideal, but you literally don't have anywhere to put things." (12603)*

> *"we look after women on labour ward with adjoining en-suite toilets with no locks. It's not appropriate in this day and age. We haven't got any facilities for husbands to stay, so if people have a really bad birth experience, the husband has to go home. The limitations within the unit has an incredible impact on staff and on patients … Here, you birth in a room, and you have to walk down the corridor with a sheet around you to*

get to a shower, and then back again, and then across to a toilet. It's not good." (12605)

As we found in the EAU microsystem at the same Oakfield Trust, staff in the maternity service highlighted a number of changing societal expectations which they felt impacted both on their own wellbeing and on patient experience. These included:

- mothers expecting 'consumer care; they think they're in Sainsbury's and they think they can just get what they like and go (12708)' and not understanding that sometimes they would not be able to go home immediately after birth ('I think everyone wants to go home straight away now … which is putting a lot of pressure on community, and one place they have cut resources is community.' (12708))
- mothers expecting continuous care from a midwife on a 1:1 basis ('I think it's just a general reflection of society … some women have very unrealistic expectations.'.(12603); 'I think some of their perceptions and expectations are a little bit ridiculous at times, and they set the bar a bit too high.' (12608))

Despite such changing expectations - and the demands they placed upon individual staff and the service as whole - staff consistently spoke of the high levels of personal satisfaction they gained from their job:

"There's nothing better than having a normal delivery with no one else, no doctors involved, no one putting pressure on you to do this, that and the other. There's nothing better. If I walked onto labour ward now and had a nice, normal, straightforward delivery, you do feel this sort of fulfilment. It's personal as well as professional … it's still there; you do feel quite honoured to be part of it." (12708)

This sense of staff dedication to their jobs was something that was noted, and commented upon, by patients: 'I mean we were in the room probably a good eight hours and she must have had quarter of an hour just to get a coffee, she was with me all the time … It's amazing; it's an amazing thing to do really' (patient 1). Such dedication did, however, raise somewhat similar issues to those in our haematology microsystem in Elmwick Trust with regard to how staff managed professional and personal boundaries:

"for the last two of three years I've sort of thought... you can't change everything, you have to leave some things, they have to work out themselves, but I used to take things home. Especially if you've had a stillbirth on labour ward, I mean I had a stillbirth years ago, I'd looked after her, thought everything was fine, had the baby's heartbeat, just expected baby to come out, and there was just something that I thought wasn't right so I moved her from a side room into a bigger room and it was her second baby so we thought it was going to fly out, but it didn't.

And that baby was dead and I still... the date every year you still think, 'Mm, did I miss anything?' even though you know you didn't miss anything, even though you've been told you didn't miss anything, even though you've been told the baby was dead a while ago, you think, 'What was I picking up? Why was there a heartbeat seemingly there?' So that's, obviously, what you take home." (12708)

"There are masses and masses to do, and it's trying to prioritise, and it doesn't really work actually…. on labour ward, if the shift comes on and someone's just about to birth, they will take you out and put a fresh person in. That makes more sense in one way, although you'd like to finish supporting the woman. But you have to be practical at the end of the day, otherwise we'd all be staying way past our shift hours, and expecting to come back the next morning. So you do feel that you've sometimes let your lady down, if you've had to go home. Especially if they say, 'Don't leave me,' and they do do that to you 'Please don't leave me.'" (12614)

A community midwife commented:

"You do have a life outside of the NHS, and I'm very respectful of people being able to go home, switch the phone off, not be disturbed with work related stuff, unless they do happen to be on call. Because I know that, for me, that's how I deal with my stress. I have to switch the phone off. I don't want people disturbing me if I'm not at work. If I'm on call, it's different because I expect it, but when I'm not on call I try and leave it at the door. And that's the only way I can deal with my job, because if I allow it to pervade my personal life, I'd be in difficulties." (12601)

The value of mentoring and supervision for establishing a supportive local team climate (and the seeming irrelevance of organisational climate) for patient-centred care

As suggested by the staff survey responses and our qualitative data the influence of local climate appeared to be an important variable in this maternity service; staff commented on how the supervisory and mentorship schemes present in midwifery, as well as the fact that most midwives continually rotated between the labour and maternity wards, and the relatively small size of the service all contributed to good teamwork and levels of mutual support (both informal and formal) in the service.

As one midwife explained, supervision of midwifery has been a statutory requirement since 1902 - when it was to protect the public against women who delivered babies without any qualifications or training - which has evolved into a system for ensuring midwives are practising safely, have guidance, are supported and have a named person with whom they can discuss practice issues. Junior midwives commented that 'I've never felt like I've been

unsupported in a situation that I'm not confident in' (12608) although, inevitably, there was recognition that the quality of supervision varied depending upon the supervisor concerned. Generally, however, formal supervision was welcomed ('it's a tremendous asset for midwifery'; 'it's an ongoing relationship, and it is a good thing, it really is) and felt to be a very positive aspect of midwifery practice, especially when combined with more informal types of support:

> *"Supervisors are always available; 24 hours a day, for advice, support, anything … It's just like a sounding-board to make sure we've covered all our bases. So we're very lucky to have supervision in midwifery. Also we've got lots of supportive midwives on labour ward. Like I say, we work very well as a team, I think ... We do work very well as a team, and we try to support each other through bad things. The coordinator on a shift will always make sure everybody was alright before they went off, hopefully, unless it was heaving, but we would always come back and say, 'Is there anything?' I think we're quite supportive in that respect."* (12605)

> *"It's like a safety net. It's not taking away the accountability of midwives; it's offering support and guidance, and advice. That's the philosophy of it ..."* (12615)

Newly qualified midwifes always have a named preceptor as well ('We have a really good preceptorship package, and a separate preceptor who's different to your supervisor' (12615)) and - other than core staff on each ward - all midwives rotate between the labour and maternity wards ('one of the reasons we work well together because … all are aware of the different needs in the different areas' (12602)):

> *"the mentor is there as a sounding-board; they're not going to the mentor for answers to a question because they've already got that. They're just saying, 'This is what I think, do you agree?' We also support newly qualified midwives in practice anyway, both with the preceptorship package, but also one of the differences that the midwifery profession has as opposed to nursing profession is supervision. All midwives have a supervisory midwife that support and guide them. We do get used a lot. It's not all big stick; it is a very supportive and guiding and developing role ...."* (12603)

Although there was some unhappiness with the rostering system and suggestions of tensions between older and younger midwives, as well as evidence of the variable quality of supervisor support already mentioned above, overall we did find a very supportive, team-based climate ('we manage to get through the busy times by relying on and helping each other'):

Project 08/1819/213

"I think you just sense it, and I think because the teamworking is so good, and probably that's a little bit more apparent on night duty when there's not everybody else around. That is very much more teamwork, and you can sense you're all so cohesive, and I'll thank them for their hard work at the end of a shift but they'll say, 'Oh, thanks for your support.' So it's those sorts of things … " (12615)

"We support each other. I think we're lucky. I have friends that work in other Trusts and I don't think they have such a happy working environment, colleague-wise, but I think we're all very good at supporting each other. I think that's our strength really, and that's how we cope." (12667)

The size of the unit - and low turnover of staff ('we have all been here for many, many years') - was also sensed to contribute to the supportive local climate and feeling valued and respected by colleagues:

" … feel lucky that it is a small unit. We hear lots of stories of bigger, busy city hospitals and it just sounds... well, I wouldn't want to work there I don't think. So I think we're blessed with being in a small unit, therefore you tend to know the staff a bit more intimately, and you know who's approachable, … you know who you're comfortable working with, you tend to know the majority of the doctors and how they work. So it is definitely much more comfortable working in a smaller unit." (12614)

The matron for the service summarised:

"I think in this unit we've got a very good team that work very well together. I know that we have very challenging times at the moment with finance, with staffing, and so I suppose morale could be worse. But because we are such a good team, and we very much support each other, I think morale is not too bad. That's the impression I get, anyway. We all work very well together. If it's busy on labour ward, I'll go and help out, staff from the ward will go and help out, which I know the staff on the ward find very frustrating and that demoralises them, but at the end of the day, they do it to support their colleagues." (12605)

What was equally as clear as the strong local climate was the seeming irrelevance of the wider organisational climate to staff. Certainly, the Trust was seen as irrelevant in terms of 'feeling cared for', and in the case of the second quotation, exploitative:

"The Trust doesn't really come into it for me. I don't even configure whether I'm cared for by the Trust. It's not something I think about on a day to day basis. The midwives and the managers that are around me, I do feel cared for by them because I think they're just around you, aren't they? They're asking you if you're alright, and, 'How are you getting on

with that?' To me, I feel cared for in that respect ... Yes, whereas the Trust, obviously you work within the Trust, but I don't think I have had contact with anybody who is anything specifically to do with the Trust." (12608)

"[INT: So if I was to ask you whether you felt cared for at work, what would you say to that?] By my colleagues, I do, but by management I don't, and by the trust generally I don't really. We have a lot of e-learning to do, that we're expected to do and keep up to date with. We're not given time to do it; we have to try and fit it in and to a certain extent, we're expected to do some of it at home … for the last two years I've done it at home and I'm not doing it this year. If I get pulled up about it, I shall just say, 'I'm not doing it. The trust wants me to do it, the trust has to give me time.' I've got to the point where they've got a lot of unpaid hours out of all of us in missed breaks, and times that we go home late." (12667)

Where the wider Trust did impact upon on staff wellbeing it was uniformly spoken of in a negative way (for example, the Trust's dire financial situation). One sister spoke of her frustration when her order for some Sellotape was denied because the Trust was so significantly overspent; she explained how the Trust bought envelopes that are so cheap that they would not stick down and now having being denied any Sellotape, was concerned that confidential information was going to be lost or misused (12601). Another staff member made similar references to being unable to *'order paperclips, or printer paper, or extra paper for various things … if you've got a paperclip to fasten onto the medical notes of all your papers … it creates organisation. But we're not allowed to have them anymore because of budgeting. Well that, for me, is a stress. It sounds ridiculous and trivial, but it actually is.'* (12615)

How job demands can limit staff capacity to give discretionary effort

As reported earlier, the staff of the maternity services had high job satisfaction, job dedication and positive affect ratings and yet, seemingly incongruently, low levels of discretionary effort. In seeking to explain this, our qualitative data point to a series of different issues that heightened the job demands placed upon maternity staff thereby, perhaps, limiting their capacity (if not their willingness) to 'go the extra mile':

- workload and delays beyond individual staff members control; staff spoke of having 13 discharges a day with all the related liaison and information-giving required to support each discharge, of not taking a break even for 15 minutes during an eight hour shift, of how the annual number of discharges had risen from 1400 to 2200 a year without any increase in service capacity or investment in the physical environment, and of the frustration caused when other departments in the Trust or

the non-availability of consultants caused delays ('*the EDD - the discharge system - causes a lot of paperwork, a lot of computer work … it's just the systems I think that's holding them up.' (12708); 'I don't like it when it's out of your control and - I don't know how else to put it - other than I'm getting it in the neck, basically, by these parents the fact that the doctor isn't coming when there's absolutely nothing I can do about it.' (12608))*

- increased paperwork due to fear of complaint and risk of litigation; staff related how it was 'drilled into them to keep documents … you document everything' with the risk of litigation 'always at the back of your mind', 'because of the complexity of what you actually do, if you increase the numbers of people you've got to do that for, it's very stressful. You live in fear of missing something vital' (12667)

- personal safety (for community midwives making home visits); one community midwife described how she visited some homes on certain housing estates as a lone worker that policeman had commented they would not visit alone and how, despite all staff having personal alarms, some incidents and social circumstances still 'preyed on my mind'

- child protection issues, safeguarding and social services; midwives spoke of their frustration and distress when babies they had delivered are immediately taking into the care of social services, often accompanied with delays in social service parenting assessments that would mean patients remaining on the maternity ward for, sometimes, several days, and of the anguish of mothers ('*I've been on the ward where women have screamed, and screamed, and screamed when their babies have been taken away from them' (12603)).* Another midwife spoke of an incident, '*l*ast week, I had to take a baby out to the car park to hand over to foster parents ... Leaving the couple upstairs sobbing – what's that all about? You know, that's the pits, that really is' (12614)*

- partners and relatives pressurising staff and not understanding that a great deal of paperwork has to be completed before a mother and baby can be discharged ('awkward family can be very, very trying and very draining', (12614); 'Visitors are a pain in the neck', (12667)

- emotional labour; midwives frequently spoke of the high levels of emotional involvement they had with their patients ('there's a lot of tears in this job, and I remember reading somewhere, 'If you want to cry while you're with a woman, then do it,' because we all try and hold back those sort of emotions, don't we, because it's not professional, but I do cry with women' (12614)) but there were limits to the amount of empathy they could offer on a continual basis ('sometimes I find sympathy hard … empathy wise, I think I try hard but sometimes I can't put myself in that person's situation because it's so far removed and so different to my own life. As much as I try and empathise with them,

and try and understand what they're thinking and feeling, it's impossible just because it's so, so different to my own life.' (12608))

Overall, however, and in all areas of the maternity service, recent service pressures were at the forefront of staff experiences ('So much pressure on a daily basis - never get an uninterrupted coffee or lunch break and frequently no break … difficult and exhausting') and these were recognised by patients:

"I should imagine it's quite hectic, non-stop, you don't get a scheduled break, you have to take it when you can, and if it gets cut short it gets cut short. They take that with the job really, the long hours and ... I think with any service, they're pushed to their limits, and they're expecting more and more of the targets to be reached." (patient 2)

"you felt that they were really busy, because you could hear either side of you in your room that there were people giving birth or wandering in and out, and things like that. So you did know that they were busy, but they didn't ever show that they were under pressure, which amazed me, because I thought, 'I'd be running around like a headless chicken,' but they were all calm and cool and things like that … didn't take away from their care and treatment of me. It was all really good still." (12581)

Despite seemingly managing to still provide a good patient experience the increasing job demands briefly described above had clearly led to burnout in some of the midwives we met and spoke to, albeit individual personal circumstances dictating the extent to which staff were able to manage this:

"I used to take allsorts home in my head to do, and I got poorly through it and I needed quite a while off at home, so no I decided that when I came back I wasn't going to do that anymore, I was just going to leave work at work. If it didn't get done you're not going to die from it, and vice versa I don't bring my home to work."

"I would say staff would get burnt out if it was busy here, but they have got other things on at home, and you can only take so many stressors can't you. If they have got something issuing at home and then it's busy here and they can't put their mind to the job, then I think that's when there's more of a tendency. I wouldn't say it's particularly unusual bad cases here that would affect them, I think that is part and parcel of the job and they can do that, it just depends what they have got on else where and how they could cope with that, that make them cope here or not."

The importance of professional identity to staff wellbeing and patient experience

We end this discussion of the links between staff wellbeing and patient experience in the maternity service at Oakfield Acute Trust with an

acknowledgement of the strong professional identity expressed by many of the midwives we met, perhaps the strongest sense of professional identity we encountered in any of our eight micro-systems. We suggest that this may explain the contradiction we found between a poorly performing organisation (Oakfield Trust) but a very positive climate for patient care in the maternity service (as discussed above organisational climate was rated poorly by staff but local climate relatively high and it seems that the former had little impact upon staff wellbeing and patient experience in this particular microsystem).

As Cooke and Lafferty describe (1), the extent to which individual staff members identify with their organization has long been recognized as affecting both the satisfaction of individual members and the effectiveness of the organization (2, 3). For example, research in the US has showed that doctors who perceived the identity and external image of the healthcare systems to which they were affiliated to be relatively more attractive tended to identify more closely with their respective organizations, which in turn was related to cooperative behaviours. Similarly, attachment to one's organization has been positively correlated with greater amounts of 'extra role' behaviour (4), such as spending time helping newcomers, working on long-term projects, pushing others to perform to higher standards, or providing ideas for improving the organization (2, 5). However, in this particular maternity service the feeling of solidarity we found emerged not through identification with the wider organization (Oakfield Trust) but through a very strong sense of professional identity:

> *"It is rewarding. I think it's a job that you wouldn't do if you didn't love what you do ... I would say midwifery, the majority of the time, is the most wonderful job in the world. (12603)*

> *"Well, I absolutely love it. I think being a midwife is something that I've dreamed of since I became pregnant, and I didn't become pregnant until I was 34. So it's a last career, a late career. To me, I don't know why everybody isn't a midwife. [laughter] I just think it's the best thing in the world … I don't know, it's just so special. I'm not a nurse …" (12614)*

It was clear that the very sincere attachments held by many midwives to their profession played a significant part in engaging staff to provide high standards of care, although the increasing job demands they faced appeared to constrain the extent of discretionary effort they were able (as opposed to willing) to provide. In addition, professional identity represents an internal, implicit and consequently deeply embedded 'check' on the quality of care. Strong positive identities can provide managers and staff with a sense of meaning, purpose and excitement, and the enduring and central traits of a professional group can constitute a relatively stable cultural 'bedrock' on which to support patient-centred care. In short, identity and identification are 'powerful lenses for explaining change, action and inaction by individuals and collectivities',

and, as demonstrated in this microsystem, professional identities can help to explain why individuals act on behalf of a service (as opposed to an organization), and the direction and persistence of collective behaviours such as individual efforts that contribute to patient-centred care.

Elmwick Acute Trust: Medicine for the Elderly

Local climate: how co-worker relationships and local leadership shape staff wellbeing, and patient and carer experiences

Summary

This case study was sampled as a low performing microsystem in a high performing Trust. Patient experience varied in the medical department for the elderly microsystem - selected as the low performing microsystem in our 'high performing' Elmwick Acute Trust - with some patients satisfied (i.e. reporting a good experience) and others much less so. Patients reflected on their experience not only in relation to their own care but in terms of the care they observed other patients receiving, and we noted a tendency for patients not to complain nor wish to be perceived as difficult by staff. Nonetheless, notable issues for patients included a lack of timeliness, a lack of attention to detail, variation in the attitudes and moods of staff and the unavailability of staff. We also observed a lack of personalised care with patients referred to by bed numbers.

A lot of staff we spoke to appeared very committed and motivated to do their best for patients; to be "loyal and very hard working" and to ultimately really care about older people, and to be incredibly motivated but they were also "all very tired". For many staff striving to maintain an acceptable level of care came at great personal cost, with a consultant geriatrician stating: "I haven't had a day off in ten years,…..(and) less than a week off since 1999". Many frontline staff felt there was a disconnect between the Trust's senior managers and those at the patient bedside; frontline staff felt senior managers - whilst appearing supportive - did not really want to listen to the complexity of the problems staff encountered on a daily basis. These difficulties included poor team working and cohesion in many areas, with some middle managers having limited opportunities to recruit their own staff and build effective teams.

Strong divisions between grades of staff and between ethnic and cultural groups - and evidence of bullying and incivility to fellow staff members - were noted; these were all perceived to undermine any sense of a 'family at work'. Also we observed a work environment where often very frail and dependent patients created very high levels of demand on staff who, in turn, felt little control over their day-to-day routines and resources. Finally, leadership and management of staff at ward level was identified as critical for setting

expectations of values, attitudes and patient-centred care and for creating a local climate where staff felt valued and appreciated for the difficult work they undertook day in, day out.

Patient experience: problematic but 'accepting' patients with low expectations

Patients cared for in the medical elderly wards were on the whole quite satisfied, and many said they had been well cared for and looked after:

 "Strange as it may seem I enjoyed my stay in x ward: I can only compliment the staff and the services they provided they seemed to work like clockwork. The staff were always pleasant especially to the patients requiring a lot of attention, no care seemed to be too much trouble" (21029 questionnaire).

Our patient survey reveals 54% of patients (n=26) rated their care as excellent and 31% very good and 58% would definitely recommend the hospitals to friends and family, with only 11% of patients suggesting they would not or definitely would not.

However, through our interviews and informal chats with patients during observation of practice, it appeared overall that patients had quite low expectations, and whilst on the wards, felt quite vulnerable and therefore reluctant to complain. Some medical staff spoke of older people *"just accepting things"* (21795).

Betty had noted in her questionnaire the poor food and the fact that the cleaners moved the bedside table out of the way to clean underneath, but did not put it back, which was very inconvenient because:

> *"on the trolley is your water, which they insist you keep drinking, and everything else, perhaps reading matter, your glasses, and all the rest of it, ….. and there are no nurses around so you just have to wait until somebody comes to pull your trolley back"* (ID 21110)

When asked if she had raised any of these issues when on the ward, she responded: *"I shouldn't think so, no; I shouldn't think I did. Perhaps I should have done" (ID 21110).* More telling was the significant aspects of her experience that she omitted from her survey response – for example, not getting the commode or bedpan in time:

> *"The other thing I didn't raise and I should have done because it does annoy me intensely, the time you have to wait for a bedpan. ….elderly people can't wait, if we want a bedpan it's because we need it now. (..) And patients get very distressed and they're embarrassed when it arrives too late – which happened to myself – although they assure you that it doesn't matter, but it matters to the patient. (..).' (PT ID 21110)*

Project 08/1819/213

When the researcher commented "I notice that you put on your survey that you felt you'd been treated with dignity at all times" (as had 89% of our patient survey respondents), Betty responded:

> *"Oh yes, very much so, every care and everything. You were never ever made to feel you were being a nuisance or ignored or anything. The whole system is excellent" (PT ID 21110).*

That this was not perceived as an issue related to 'being treated with dignity' is surprising, but the differences between private accounts (at interview) and more public accounts (in questionnaires) was explained by this patient: "I didn't want people to think, 'Oh, she's always complaining,' you know, take that sort of attitude" (21110). As a vulnerable patient potentially fearing repercussions from staff, speaking out at the time was reported as difficult. Betty, also witnessed what she described as bullying (see below), but felt unable to speak out on behalf of others; "I suppose I was a bit of a coward. I should have said I didn't like what I heard'. We suggest that patients undertake a great deal of emotional labour when managing relationships with a plethora of staff, and are keen not to be seen as a nuisance or a 'problem' patient. Yet the issue of timeliness of care raised by Betty was a recurring issue with patients we observed and spoke to. Bedpans and commodes were not brought swiftly enough, nor were patients permitted to have a commode by their bed at night to help relieve the anxiety that delay or travel distance evoked (Here it's a long walk to the toilet Enid, 85):"I can't have a commode by my bed, they don't let me have it. I did ask, and they said there were only four commodes. That particular nurse was quite rude about it".

Patient experience: variations in care

Patients frequently made distinctions between particular staff members - as in the preceding quotation - and noted variations in the care given by different individuals. Staff were characterised as 'nice', 'kind,' 'cheerful' and 'gentle' or 'grumpy', 'rude', and 'rough'. Many patients also mentioned tone of voice or body language as ways of conveying negative emotions; some also suggested that the variation - and serendipity - of patient care was dependent upon staff mood. Gloria, 93, wanted a commode by her bed, after some persistence she got one: 'Breaking the rule, I heard her say. All the other nights I've had no problem, it was just this one. From 6 am I started dreading whether I'd get one or not. I'd had one explosion in the bed and I didn't want another…. It depends on what sort of mood of the night worker' (Field notes JM 100710).

A consistent variation cited by patients was between night staff and day staff, with night staff frequently reported as tired, grumpy and generally less tolerant. Joan repeatedly said that at night "staff are short, they tend to be tired, but they are irritable" (MA field notes 110610). Another patient said "The only thing really is the night ….She was rough, not only with me, but

that's my only grumble (..) a couple of people make it a bit awkward, being rough and tone of voice" [JM field notes 070710] and bullying was mentioned by some patients as more prevalent at night: 'Some of them are okay, they're nice. Some of them are bullies… (and) at night they don't want to be asked to do anything.' [JM field notes 100710]. Rose, 86, said, 'It's quite nice here. You get one or two of the old hands do a bit of bullying. The other night … (she) couldn't get her own way…. with one of the ladies, and had her crying …. she wasn't very pleasant at all. I felt sorry for them; I saw them crying".

Thus patients clearly evaluated the care on the ward in part by noting whether other patients received good care or not:

> *"I saw elderly people sat in the chair, who didn't complain, without any slippers on their feet and it was quite chilly. (..) and there were a number of quite sick elderly people, (..), who could not feed themselves,(..) and I would see their meal placed on their bed table and left there and no one appeared to come along except to take it away again, which I felt should not have happened". (PT ID 21099)*

> *"I actually saw a lady opposite me, who was listed as a diabetic (..) I noticed (..) a senior nurse – she noticed that she hadn't started her meal and she sat by her bed and fed her…. So if somebody came by and saw that the lady wasn't eating they fed her. I think that was an act of kindness." (PT ID 21099)*

Another patient also spoke of witnessing good care, and highlighted the difficulties she perceived for staff in caring for elderly people ("some obviously, very gaga"), on the same ward as her. When asked what it was like for staff working there, Betty, 85, suggested it was "Pretty grotty. The smells for one and people are moaning and groaning all night long." She went on:

> *"I did say that to one of them, I said, 'You know, this must be one of the worst possible wards to be on.' But they were so bright, and cheerful, and happy and they said, 'Oh no, I've been on it four years, I wouldn't have stayed if I didn't like it.' I think they just got so much satisfaction out of making people comfortable and making life a bit happier for people. That's how it appeared to me anyway" (PT ID 21110).*

Another, Gloria suggested 'I shouldn't like to work here' and Rose, reflected on the number of deaths and the effects of this on staff:

> *"I think that it must be traumatic in lots of ways. Obviously, they're faced with a number of people who don't recover, who die. In fact, on the first admission three patients died in the ward I was in, in a week, so that must be traumatic for them to deal with that". (PT ID 21099)*

Project 08/1819/213

Thus patients did have an appreciation of the work staff undertook and the emotional demands placed upon them. Many also mentioned the time consuming nature of the work:

> *"everybody in that ward was very ill and they spent so much time looking after them. They could spend an hour changing someone's dressing or giving them a bed bath or something"* (PT ID 21110)

> *"The paperwork, of course, is so tremendous these days that everybody is filling in forms and charts and everything else which leaves less time by the bedside. That's how I saw it".* (PT ID 21099)

As in adult community nursing services 1 another common distinction made by the elderly patients we spoke to, was the presence of black and minority ethnic nurses, or what patients often referred to as *'foreign nurses'*. On the whole their comments and stories of these staff were negative.

> *"When foreign nurses are taking care of you - and I particularly make this point of the Filipino nurses - they will continue to talk in their own language when they're over your body in the bed. I think that's a bad practice and that happened quite a bit, because I was flat on my back for over a month and I experienced that"* (PT ID 21099).

> *"I found the other old people who were hard of hearing had great difficulty understanding the many 'foreign voices'"* (21057 open comments in questionnaire).

Patient, relative and carer experience: functional (but not relational) care

The staff we spoke to varied in their opinions of the quality of the patient experience on their wards, with some feeling it was good and the type of care they would wish for their loved ones, whereas others suggested it was 'fair, hopefully' (21736) and conceded that 'some people wait a long time to get any help' and that the 'buzzers might be going off for quite a while' (21736).

Our observations also highlighted a number of other concerns. There was a strong tendency for patients to be referred to by bed number, rather than by name, and some patients were either not greeted at all, or not greeted with any warmth.

> *"Healthcare assistant Tina goes to patient Penny, 95 years, sitting in a chair. She does not greet her; she says, 'I'm going to help you into bed.' She doesn't introduce herself - although it could be that the patient already knows her - but she doesn't say hello, she doesn't ask the patient if she would like to go back into bed"* (Field notes 7/7/10).

> *"The healthcare assistant asked for help 'with side room two', again talking about bed numbers".* (Field notes 7/7/10)

This was noted by a student nurse on ward 1 who was critical of staff referring to patients by bed number and not building rapport with patients, which for her meant not getting to know them as individuals or to know their names. Doctors tended to use patient names and then were reminded by nursing staff of the bed number, particularly if they were going to the bedside, but between nursing staff patient names largely didn't feature and bed numbers were used almost exclusively. This dehumanising aspect of care was not lost on patients, one of whom said she often felt rushed, "in the end, I feel like I'm being moved around like parcel, I'm being moved like a parcel from chair to commode to bed. I feel like a parcel and not a person anymore". Our patient survey revealed that the department for medical elderly had the second lowest ratings in the PEECH scales of the four acute microsystems (and third lowest overall) – with a standardised mean of 3.61 (Emergency admission unit had the lowest with 3.41), and, perhaps unsurprisingly given the issues raised above, 'level of connection' being particularly low (1.56 compared to 2.11 in haematology).

We also observed staff avoiding relatives and been evasive in answering relatives questions. On ward 1 visiting hours were severely restricted (on wards 2-4 much more relaxed and open), and a discussion between healthcare assistants in a ward meeting that we observed revealed a degree of antipathy towards relatives, with some staff perceiving them as in the way 'If you allow relatives any time they interfere' [JM field notes 070710].

Relatives we spoke to on wards 1, 2 and 4 suggested that on the whole staff did a good job in what was perceived to be difficult circumstances, but noted 'it feels all very busy', which often meant their relatives did not get the care they would have wished for their loved ones: a daughter reflected that "more staff are needed for feeding patients" (her mother had lost a stone in 9 days) and she had asked the nurse for a commode for her mother and the nurse had said "she's not my patient, I'm not supposed to come down that end", which caused the daughter to say "well give me the commode I'll take it" because she didn't want there to be an accident. Other relatives said "it's difficult to get information" and when asked what they thought of the care said "not much" and asked if the care was good said "to a degree" (ward 1). A husband and daughter had visited their wife/mother on ward 1 and noted the doctor had said to the nurse, 'Would you please straighten Mrs F up and make her comfortable?' and they sat there three hours and no-one came. The husband went on: "She hadn't eaten anything, she's deaf, she has no idea of what we're talking about, no-one offered to feed her, there was no straw to drink with there was no glass. Someone placed a bottle of water on the table with pills and walked away and she can't swallow because of the stroke. I don't know whether she took them or not."

Ward 2 had received a series of complaints from relatives about "staff nurses not engaging with relatives" which took the form of "the staff nurse didn't seem that interested". A senior nurse reflected: "some staff do find it quite difficult to communicate with people, with relatives and carers that are quite difficult" and if they feel the relative might complain staff tend to … "avoid that relative, and actually it's the worst thing they could do". She suggested staff found such interaction stressful and difficult "so they just walk the other way, which isn't helpful, but that's the way that they feel that they can deal with it." (21605).

We noted little social engagement with patients by nursing staff; on ward 4 the ward cleaner played a crucial role in chatting with patients, and on wards 1and 2 student nurses engaged patients, but largely there appeared little attempt to build relationships with patients and talk about anything other than the purely functional aspects of care. Building relationships, engaging in relational as well as functional aspects of care and engaging with patients and relatives was largely not happening in this service. Our analysis of the observation and staff data suggests several reasons for this which we now explore below.

Staff wellbeing: A team in name only

> "The NHS doesn't seem to care and there is no such thing as a team, everyone's individuals" (ID Number)

We interviewed a wide range of staff across all wards in the medicine for the elderly department, including health care assistants (n=4); registered nurses (4), senior clinical nurses (2), a student nurse (1) operational manager (1) and doctors (6), including 4 consultants. Like other microsystems we studied there was perceived high demand and little control - "we *have really heavy nursing needs and hard work for the nurses" and "we are stretched a bit thin on the wards". Patients* were sicker than in the past and highly dependent on nursing staff for care: *"we're getting a very much more complex, frailer, older patient,…compared to ten years ago, ….. we regularly have 100 year olds on our wards, and the majority are in their late 80s or 90s"* (21795). Staff spoke of patient's care demands yet sometimes saw these same patients as 'demanding', presenting different, but overlapping ideas which were apparently indistinguishable for staff at times. Many staff highlighted that the care they wished to give was not only physical care but psychological care, to get to know people and to have time to chat to them as well as attend to their most intimate and basic needs, yet this was not possible. However, rather than describe similar issues noted in several microsystems, we highlight some particularly interesting survey findings relating to variations in staff wellbeing between the four wards that made up the service and explore factors that might explain them through our qualitative data. Overall co-worker support items in the staff survey in this service were the lowest reported (mean 3.83)

across the four acute microsystems (and second lowest across all eight microsystems with only ACNS 1 lower- mean 3.55). Our qualitative data revealed team functioning and cohesion varied between the medicine for the elderly wards and that these factors strongly influenced staff wellbeing and the climate for patient care.

On some wards [2 and 3] there was perceived good co-worker support that was borne out by further in-depth analysis of the staff survey with ward 3 having the highest co-worker support (mean 4.6) against wards 1 and 4 (each with a mean of 3.8). Healthcare assistants and trained nurses on ward 3 suggested they worked well together citing trust and respect in their relationships: *"I think generally we're quite a good team. We all get on really well…I think us as HCAs do feel that we can count on our staff nurses to help us out and to realise what's going on, and vice versa. I think there's a lot of trust and respect between us. (21660)*.

> *"(ward 2) - I think it's good, I think team working is pretty good. I think there's quite a high degree of support. I think that the whole team tends to work as a ward, there's quite a high degree of professionalism in that you know if you're struggling or somebody else is struggling, I think we all try and help each other out." (21634).*

Where there was good team cohesion (ward 3 for example) the ward manager was seen as important in terms of team building and also climate for patient care and staff wellbeing. Within this team the ward manager was cited as excellent, and had been allowed to hand pick her team, a crucial element in that team's success (see below).

Staff in these high quality work climate areas (wards 2 and 3) were relatively slow to criticise other colleagues, including 'foreign nurses' (*"we do have quite a few foreign nurses but they're fine"* 21660); were more understanding and supportive of each other and could see the benefits of good team work for patient care:

> *"I think they (patients) enjoy the friendliness of us all, because we work well as a team, I think that they pick up on that. I think when you get a team that don't talk or, 'I don't really want to work with them,' or you can hear them whispering in the corner about so-and- so, I don't think that's a good thing." 21660*

On the remaining wards (wards 1 and 4) teams were not functioning as well which made them much more demanding places to work. Teams on these wards were not cohesive, they were not strongly supportive of each other and did not "pull together" to enable efficient and high quality patient care. Camaraderie, teamwork and support for each other in the nursing team was said to have been eroded on some wards over the past 5-10 years, with analysis revealing three factors that had led to an 'us and them',

24

heterogeneous and - at times - dysfunctional nursing team which impacted upon the strong sense of *'family at work'* (21754; 21736) that had prevailed in the past:

- strong distinctions and divisions between grades and groups of staff
- an increasingly multi ethnic and multi cultural nursing team
- bullying and incivility amongst staff

Strong distinctions and divisions between grades and groups of staff – "we were all equal" now it's "them and us"

In some ward teams (ward 1 and 4) there was distrust, resentment and a felt lack of support and belonging between staff. This could be within professional teams across the microsystem – for example, consultants not feeling supported by junior house officers, some of whom themselves felt isolated and unsupported with few friends and peers, and having to work alongside stressed senior colleagues *"the consultant is always in a bad mood, and … tends to scream and yell at people"* and within the nursing team, *"on some wards there is very much a HCA/staff nurse divide" (*21660). Consultant physicians spoke of not getting to know their junior staff because of the new rotation system so that SHOs were only in one place for 4 months. Junior medical staff spoke of isolation, high workload and the need to debrief with peers. One SHO we spoke to was well supported in this respect, the other isolated: *"most of the time you don't ever get time to do anything else apart from the work… you hardly see your colleagues in terms of other house officers" (DR-HO needs ID).*

Health care assistants spoke of changing relationships between themselves and the qualified staff "I think we've become more dictated to. Even with breaks, you're not asked anymore, you're told when your break will be…the routine has changed, and you're told – you're not asked... they just don't seem to want your opinion". (21736). Overall on wards 1 and 4 healthcare assistants felt that registered nurses did not undertake enough hands on care and did not support them in their work sufficiently.

> *"it's changed a lot…when I first started....we were all equal, but we all had our different jobs to do… that no longer exists on the unit, it is a case of the staff up there and the Level A Grades and HCAs are down here…. the HCAs ..they're there to do all the mopping up and the toileting, and all the dirty work for the staff doing all the paperwork, which I understand, but sometimes we need the help of the staff nurses because if you're on your own and the buzzers are going you can't answer every buzzer" (21771)*

Staff felt this impacted on camaraderie: "things have changed over the last few years, now the trained nursing staff spend a lot more time behind a desk (...) which leaves less people on the frontline doing the work, and it does get

on your nerves to be honest. I think their training's wasted if they're doing paperwork that an office... (..) they've done all this training to deal with patients, and they're sitting behind a desk" (21736). Registered nurses also felt the change, lamenting loss of hands-on patient care: 'I've had nurses saying to me I'm going to be a healthcare assistant today. That means I will actually be able to give patient care. But we'd all like to do that. I'd give my eye teeth to be hands-on. Sometimes you get so bogged-down sorting out discharge, talking to social workers, relatives….' [JM field notes 100710].

There appeared to be a lack of appreciation of each other's roles, and lack of support for each other. A registered nurse who had previously worked on ward 1, where she had thought of leaving nursing, was now working in another speciality where she was much happier and more satisfied at work – key aspects of this was better leadership and organisation, fewer patients, less demands, but most critically supportive colleagues – "here it's like a family" where staff help each other- previously there was no team support and it 'wasn't a very good collaboration with the team" a "rough relationship" between healthcare assistants and registered nurses.

Multi ethnic and multi cultural nursing team: "We don't seem to be held together"

Almost all staff interviewed, including medical staff, identified the challenges of recruiting nurses to work in elderly medicine: "Lots of people don't want to work in M for E because it's heavy and mentally quite taxing" (21606; 21602). For the nurses in the team there was an indication that medicine for the elderly was not a popular speciality and was seen as 'a dead-end part of the service' (100610) where "You can't go far" [JM field notes 070710] and "an area where you aren't picking up skills" (100710).

Recruitment of overseas educated nurses had long been a solution to this recruitment problem and staff who had been in the Trust for several years highlighted the global nature of this recruitment, which reflected recent migration trends, with staff from Ireland, then Sweden, Spain, and more recently Africa, India and the Philippines. Each group were felt to have different strengths and weaknesses:

> "*14 years ago, they were Irish nurses, and they'd been nursing for a while. Then we had the African nurses which were basically the same as us, but when the Filipino nurses came on, they're brilliant nurses, but in their own country they don't do hands-on care, because the family's do it. …. paperwork is their priority … it's not their fault, that's how they're trained" (21771).*

Critique of staff trained overseas, was contentious, with staff sensitive to - and keen to avoid - charges of racism. One medical consultant suggested: "*I think*

Project 08/1819/213

people mix up being able to explain to people that their language skills are poor with being racist, and it's nothing to do with that at all" (21601).

Staff reported a lack of shared identity, lack of cohesion as a team; on some wards staff, from the same ethnic group, coalesced into working together-another 'us and them' scenario. One healthcare assistant suggested that a sense of 'family' was lost: "Well, it used to be more of a family affair. We used to go out… and chat. These days, we don't do any of that. We don't seem to be held together." (21736).

At a group meeting to introduce the project, some overseas nurses present said in front of their colleagues, 'I've been here for two years and the white staff don't speak to me" (GR field notes). Our observations confirmed some staff as socially isolated on wards, with little contribution to social conversations. Cultural differences were reflected in some conversations, but not well understood or respected by those on either side of the conversation, so that an apparently simple conversation about cooking revealed a clash of norms and expectations around women's roles that fed into views in the workplace about people as lazy or energetic, and as capable and incapable (MA field notes 110610).

Consultants highlighted other cultural differences such as the unquestioning approaches of staff from the Philippines to medical directions: "although they are very hardworking, the attitude… is that you do what the doctor tells you to, and you certainly don't comment upon the doctor. If the doctor says something, that's fine, you do it, and ….they'd never dream of questioning" (21795).

Incivility and bullying at work: "There is an undercurrent of bullying"

Relationships with colleagues at work are known to be an important aspect of supporting wellbeing at work. The staff we interviewed reflected the importance of relationships by highlighting the value of friendships at work, the positive impact of supportive, kind and helpful behaviours towards each other and conversely the lack of kindness, incivility and bullying. A student nurse said: "if I had a terrible day, it would be more to do with other staff members than patients…. if staff were being not very nice. That would be a horrible day." Incivility and bullying also created another 'them and us' workplace culture in two of the medicine for the elderly wards.

Several interviewees mentioned bullying when we spoke with them. In some wards (wards 1 and 4) powerful groups and cliques of staff went unchallenged and on ward 1 staff reported an atmosphere because of the 'healthcare assistant mafia' and that the ward had "lost a lot of good nurses because of it". "If one kicks off they join together, there's a ringleader, it's very much a 'them-and-us' atmosphere – nursing staff, ward clerk and management versus the healthcare assistants" (JM field notes 7/7/10). Another member of staff, a

healthcare support worker, had been bullied for many months by a ward manager and - after being moved to a different ward for one shift - another ward manager commented : "'I can't believe you've stayed here for two years being bullied like this' (218181).

As well a direct bullying, on wards 1 and 4, many staff highlighted a generally tense atmosphere, harassment and incivility and a generally unsupportive climate - for example; "There was a lot of back-biting" (218181) and "eye rolling" when certain members of the team spoke in ward meetings; "(she) was sitting there rolling her eyes. And she has a habit of making you feel really small and that you're not doing your job" (218181);

"There's a fair amount of, I'd say, bullying, if you like, goes on, on the ward, depending what staff you're working with. (It's) not outward. (..) There is an undercurrent of bullying" (21736). This member of staff felt she could stand up to it, but it made for an uncomfortable working environment which was felt by all - including the patients: "It does impact on the day, on that particular working day, yeah. We all feel that" (21736). The research team observed some of these intimidating behaviours, particularly staff being critical of each other and eye rolling in meetings and handovers on ward 1. The effects of this was some members of the nursing team being isolated from others, of being blamed when things went wrong and their work called into question. It created an environment where it became too 'dangerous' to speak out and where some staff felt unable to challenge bullying behaviour. In terms of patient care, staff suggested powerful staff were not challenged even when other team members disagreed or disapproved of their attitude and behaviours towards patients, and reporting such behaviour had become increasingly difficult.

Such negative workplace behaviours, whether witnessed or directly experienced, are reported to negatively impact upon staff motivation and job satisfaction and create resentment in staff (6).

Finally' given the noted variation between the four wards that made up this micro-system we examine the crucial role that ward leadership and management played in the wellbeing of staff.

Leadership and staff management: "I think that kind of helps if your management are open to you".

Just as patients noted variation between staff, staff noted variation between leaders and managers. Doctors identified great variation between ward mangers "There's great variation …the ward manager's role on ward 3 is fulfilled absolutely, almost perfectly, …by a very dynamic person who does liaise, who knows everything about the patients when you arrive, and who is able to facilitate and wants to keep the ward moving and turning over" yet "There is great variation on the other wards" (21602).

Nursing staff views of their leaders and mangers were polarised across different wards, with some openly critical or in the case of two wards (2 and 3) supportive of their local manager, depending upon their evaluation of them in terms of supporting the team to deliver good patient care. For example, behaviours that were liked by many nursing staff were 'hands on' managers: "our manager's very good; she's hands on; she'll get on the ward and help out with the patients with an open door "you know that she's always there. The door's always open if you need her for anything…. whereas you get some that just want to shut the door and don't want to know (21660). Similarly an excerpt from our field notes reveals: "staff told me that they felt great on the ward since this new unit manager had arrived, particularly the Band 5s. They felt that Alice was a wonderful role model. They appreciated the fact that she'd taken each member of staff to one side and spent at least two hours having a conversation with them. Also a number of staff commented, 'She doesn't just hide in the office, she's on the ward.' So they felt very positive". (MA field notes 100610)

In contrast staff were also clear about what they did not appreciate in managers and suggesting that autocratic, arrogant and unsupportive leaders create a poor work environment for staff wellbeing. For example many staff spoke of a senior clinical nurse who: "caused a lot of trouble. (..) s/he'd come on the ward and order you to do something whether you were busy, gowned up to do something or not. You immediately dropped everything to do their bidding. I've never known anybody ever in my working life here anything like that before." (21736). This senior nurse was not respected by ward managers, who saw him as unsupportive and muddled with no clear vision: "He hasn't supported them when they've needed it, but he has gone over the top on small points when they've been really not in the mood for it" (21606).

Ward managers, keen to improve the experience of patients, adopted different strategies for influencing staff behaviours. On ward 1 staff were told buzzers were ringing for too long and that they must be answered more promptly; staff suggested this felt like an extra demand in an already very demanding environment. On another ward (ward 4) a relatively new ward manager, Alice, argued that the key problem was both low staff morale and staff not answering patients' buzzers. She invited nursing staff into a room where she gave each member of staff an ice cube to hold, and she asked them to hold that ice cube for ten minutes, and she said, 'You trying to hold that ice cube is how patients feel when they want to go to the toilet, and they're holding it because nobody has answered the buzzer.' And this really had quite a profound effect particularly on two of the Band 5s [staff nurses]." (MA field notes 100610).

The Trust had experienced a relatively high turnover of ward leaders and staff were de-motivated and worn down by each new starter coming in with good

Project 08/1819/213

ideas only to leave soon after: "While we were without our ward manager we had stand-ins. One come along and altered this, and then another one come along and altered that to this, and you think, 'Oh, just leave it, let the new manager do it.'.. Then we got a new manager, Gail, brilliant, but then she left. 'Oh, crikey,' and then at the beginning of this year we got another new manager, but then she left, …, and we've now got another manger, which we're hoping will stay, …. it's been very, very hard to settle as a ward, and run as a ward, because you haven't got that leadership". When Alice the new ward manager started on ward 4, no-one would speak to her. "Staff were so negative about management and particularly about unit managers and ward managers, that no-one would speak to her…... she managed to engage by getting out onto the ward to make beds and to discuss patients and to discuss events with staff while she was going round, involved in quite basic bedside tasks. She said that now she realises that the most important thing for staff is to see her on the ward, and two Band 8s and two HCAs all told me that they now have a manager who is on the ward and who works on the ward with them." (MA field notes 100610).

Critical for a cohesive team and good patient experience was staff recruitment and selection. The Trust had recently reversed a policy which had meant some ward leaders were not able to recruit staff to fill their vacancies. The Trust held recruitment open days where staff were selected by senior managers and then divided up between wards with vacancies, so often ward managers were not able to recruit their own staff to work in their ward areas. A senior manager was critical of this policy and reflected on the situation in one of the wards: "to have lost 80% of her staff and have them replaced and never chosen one of them, not one of them herself, it's not surprising that there are problems" (21606). On another ward (Ward 3) there was a very different situation: "she was able to choose her staff ….she got the opportunity to build, to construct a proper team and then do lots of team building work with them. And we do get fewer complaints, fewer incidents, lower sickness, lower turnover, and it is down to good leadership and building your own team" (21606).

Ashcroft Trust: Community Matron Service

Managing on the Edge: service innovation, good patient experience and poor job satisfaction

Summary

This case study was sampled as a high performing microsystem in a low performing trust. This Community Matron Service in Ashcroft Trust indicates the importance of interpreting survey findings of felt job satisfaction within the context of particular service histories. In this service the felt and recent withdrawal of organisational support and direction for a relatively new community service led staff to feel a deficit of organisational support for themselves and, indirectly, for patient care. Staff felt the effects of organisational realignment, and particularly of felt withholding of supervisory support and training even though organisational investments in their training and professional development remained substantial. Indeed, the microsystem study suggests that it is not only what organisational and service managers do but how they do it that matters to staff.

Our study also found a clinical microsystem where despite poor job satisfaction amongst staff they still provided patients with a good experience of care. The patient interview and observational fieldwork indicates the importance of situating patient survey data for this microsystem within the context of a particular patient demographic. In the shorter term staff continued to give discretionary care to patients despite poor job satisfaction. In the longer term staff planned to leave or left this service.

This microsystem illustrates that felt job satisfaction must be examined in relation to particular histories of service development   While the senior professional staff working in this service appeared to be in receipt of many antecedents of employee wellbeing, a change in felt organisational support for this service (and, in particular, the way that this change was managed) had an important impact on felt job satisfaction. Following JD-R theory, the felt lack of job clarity for staff, along with the felt lack of organisational support, supervisor support and co-worker support, led to a situation of poor job satisfaction. This occurred despite the felt work autonomy and limited job demands (in terms of amount of work expected in a limited time) on staff. In terms of CO-R theory, the - albeit limited - survey data for this microsystem indicates that local workgroup climate is less influential than organisational climate as an antecedent of staff wellbeing. However interviews and field observations indicate that staff perceived local workgroup climate as very

divided, not least because there was limited opportunities for team working or building co-worker relationships due to the nature of the service.

Service innovation and the value of a champion

Phase I manager interviews and Phase II staff interviews indicated the critical importance of the Director of Community Health Provider Services to both champion the pilot and 'rolled out' the innovative service and to protect the service from early dissolution following the rapid implementation of the Transforming Community Services (TCS) agenda within the provider service organisation from 2007. In 2009 this Director of Community Health Provider Services insisted on the importance of protecting this service through the TCS process as well as identifying ways that this service model could be rolled out to other service areas (children and young people's community nursing services, for example). At interview she observed that "our community matrons are a bit wobbly at the moment because we're asking them to integrate a bit more with [generic] community nursing… they are a little bit elite, which is no bad thing… we are thinking of how to boost [other community services] that allow this service model to continue".

Later in 2009 the Director of Community Health Provider Services took a job promotion outside of the organisation. Her leaving left this specialist service less protection from economic rationalisation by a succession of Heads of Community Nursing Services (who all felt that the specialist service had been unfairly privileged compared to generic community nursing services). By mid-2010, when Phase II staff interviews and observation work was underway, both community matrons and several ward administrators were 'feeling the pinch' of a far less supportive and more punitive service and organisational climate. At this time staff were critical of the felt lack of service and organisational support of their work and many anticipated leaving their jobs within the year. The limited survey findings for this service also indicate that staff were very negative at the effects of organisational climate, and particularly of the lack of supervisory support for their patient care work. This microsystem scored lowest of all other eight microsystems (community and acute) for felt levels of organisational support and supervisory support amongst staff.

Project 08/1819/213

Service vision and reality (2009-2010)

In 2010 the key elements of this specialist service were 9 or 10[1] 'community wards' each accommodating between 46 and 60 complex needs patients at home. Patients on each ward were case managed by one community matron (in her absence one other matron who managed a parallel 'community ward'). Officially, the service operated weekdays only (9am-5pm) with the majority of matron visits to patients and services organised as advanced bookings. In reality many matrons worked either compressed or part-time hours which meant that their availability to patients was often limited, not least because part-time matrons carried the same patient case load as full-time matrons. Also, however, some matrons made themselves more available to patients with particular clinical or emotional needs than other matrons did and some matrons extended their working day to occasional 'out of hours' visits and other matrons never did this.

The particular role of the matron was the improvement of co-ordinated care between various professionals and agencies and improved patient communication. However all matrons highlighted the critical value of their consistent, personal relationship with patients "to people's confidence in caring for themselves" (600). The majority of the community matrons (who were all recruited at Band 8) were formerly senior clinical nurse specialists or senior district nurses. Another key element of the care management and patient and staff communication was the dedicated ward administration system. This system, operated by 5 ward clerks (later renamed and re banded 'ward administrators' in 2007) was the linchpin for the co-ordination and daily support of patients. Each administrator worked across 2 wards and remained in regular (sometimes daily) telephone contact with patients or carers and disseminated information and coordinated patient services between acute, primary and community health professionals, other services and the community matrons. These ward administrators, who received remarkably limited training in patient information and patient support, were most often the first point of service contact and co-ordination and advice for patients and carers.

Patients were admitted into the specialist service through a distinctive procedure. They were first identified 'at risk' by a specialist computer algorithm and were then invited to consider consenting to receiving the specialist community nursing service. Following an informal booked visit with their potential community matron patients might sign a formal consent to the

---

[1] All PCT and Community Provider Services documents reported that 10 wards each staff by a community matron are in operated however this never seems to have been the case. By late 2010 fewer than 9 community matrons were funded by the service.

Project 08/1819/213

service accessing their GP and hospital records and so be admitted to their service.

Patient care management plans and progress reporting was complemented by a service wide 'traffic light' system that recoded all acute readmissions risks or care management need for each patient. This system also operated as a service wide performance indicator (recording the changing frequency and duration of each patient's hospital admissions).

Ideally, patients moved from more to less intense case management requirements over time and were discharged from their service according to either their own clinical progress (sometimes gauged by their declining risk of acute readmission) and in relation to other patients newly arrived in the service.

In reality the vast majority of patients remained in the service for many months or years and received more or less intense community matron care depending on their fluctuating clinical conditions. For various reasons (including difficulties with obtaining GP cooperation and some patient's reluctance to give written consent to receive the service) the service never ran at its proposed capacity of 10 wards each accommodating 100 patients[2].

Patient experience

<u>"This is something very new.." (32001)</u>

The PEECH survey of an albeit limited number of patients in this service (n= 16) indicates that patient experience of care, including emotional care, in this microsystem was relatively high however not as high as in one generic adult community nursing service (Larchmere Service 1). The particular characteristics of patients within this microsystem, and particularly their previous experiences of health services, must be considered in relation to these survey findings.

Patients admitted to this service were those who had exercised a high demand on primary, acute and community health services for many years. Many were personally known to staff within these services because of their frequent attendance or their distinctive and enduring health care needs. Phase II interviews with patients in their microsystem also indicated that many of these patients felt poorly served or misunderstood by health service and by health service staff. Several patients described that they were angry or aggressive at their first meeting with the community matron. Thus one young man with complex physical disabilities explained:

---

[2] Indeed, all community matrons interviewed felt that this was always an unrealistic number of patients for them to case manage.

Project 08/1819/213

"When I first met [the community matron] here I was very cold, I was rude..but she said 'under the circumstances of what you've been through, how the situation has affected [you]...I'm very sorry' and so I explained to her that it wasn't her fault and I said 'at the end of the day you've got to earn my trust and I've got to earn your trust.. and she's earned my trust .." (32024)

The community matron in question told me, in front of this patient, that when she first met him she felt worried about what he might do to her or himself because of his anger.

It took most patients several months to understand the distinctive approach of the service. Patients more recently admitted patients told the researcher that they felt that the service was "old hat" (32016) or just another duplication of what was already provided (32004). Over time, and particularly after a period of exacerbated illness that triggered the intensive support of the community matron to organise services and support the patient and family, patients and carers felt very positive about the support they received. Interviews and field observations indicated that, during times of exacerbated illness, patients received daily or twice daily home visits from their matron that could last up to an hour each time. In addition, they could be in contact with the ward administrator between these visits. Patients found it more difficult to estimate the time that staff spent co-ordinating necessary services. However even very elderly and frail patients remembered the details of times when their community matrons had accompanied them to hospital appointments or case review meetings for several years after such events. Overall, there were three main reasons why all patients felt very positive about their community matron and the ward administrator (who were often thought of 'as one').

First, most patients valued their matron as a senior health professional (who carried authority with GPs and other health professionals) and so could advocate for them. A matron's "contacts" (32000) improved access to urgent hospital appointments and transport, to allied health domiciliary services, to technical aides and devices, to housing assistance, local charitable initiatives and to social service assistance. One patient argued that a community matron's correspondence should carry legal authority (32024). Another matron was noted for being able to "coordinate all the doctors" (32004). Patients also felt that they were more likely to be heard when they were accompanied by their matron on a visit to their GP or hospital.

Second, patients identified their matron's unusual combination of clinical knowledge and social accessibility: "it's like talking to the doctor but better than a doctor because of her approachability" (32027). The matron was able to "notice the little things" (32xxx) and there was "no fooling her [about my health] because she can see right through me" (32024). One elderly patient with dysphasia described her unusual experience of talking to a health

professional "who doesn't help me out and waits and listens" (32002). Patients in this service often noted the felt connection between good emotional care and the support of their chronic health conditions. They felt that the interpersonal care that they received from their matron and ward administrator – "the tone of voice" (32001); "never making you feel rushed" (32xxx); "being light and open" (32024); ""not pushing me around" (32025); "to make you feel that you are the only person she is dealing with" (320sp) – was an unusual and highly valuable experience for them.

Third, patients valued the sense of some matrons' ready availability to them (even through it was most often the ward administrators who sustained this sense of "always being there" (32100)). Patients in some wards recalled at least one time when their matron had telephoned them at an evening of a weekend to discuss test results or a changes in their illness condition. Thus the wife of one patient remarked:

> *"She [his community matron] kept calling us through the day [Sunday] because his name came up that he'd gone to A&E and she was panicking and asking us if he was OK"* (32024).

"She's the one person who gets me through…." (32001)

The most notable and shared dimension of patient experience of this service is the sustained and enduring interpersonal relationship developed between a patient and the individual matron (and ward administrator). All longer standing patients noted that this relationship, and particularly the emotional dimension of this relationship, was a crucial and positive aspect of their care experience and their clinical management.

For example, one middle-aged widow, an insulin-dependent diabetic with a long history of self neglect described the multi-faceted and evolving nature of her relationship with her community matron that had developed over two years of intensive case management. She noted the different times that her community matron had been maternal, "a mum of a mother", "honest and straight forward", "not too pushy", "honest, patient and listening", "not treating me as if I am stupid" and "always noticing the little things about me". This patient echoed the views of many other patients who noted that their community matrons had "an awareness of my sensitivities and my background, of what is going on for me" (32006).

Similarly, the wife of a young man, with multiple disabilities following a series of medical errors, commented that "it's like she knows where we are at... like when we are feeling up or down and how she needs to approach things that [visit] day ". Another patient commented on the value of having a professional "who only has to look at you to know how you are feeling" and another noted how "she notices every little problem with you" (32001).

Project 08/1819/213

One notable aspect of patients' experience of such a close and extended relationship with one or two clinical staff is how patients understood staff involvement and motive. Patients, like staff in this microsystem, often reiterated to the researcher and to one another the purpose of the specialist service: "to prevent hospital admissions" or "to keep me out of hospital". However patients found it difficult to understand the relational care of staff according to this rationale. They often explained the extraordinary emotional and social care of patients by some community matrons as a discretionary aspect of professional work. Patients explained their experiences of staff "going the extra mile" in two ways. They explained this either as a result of that health professionals' exceptional dedication to their work and the values of patient care or as a result of their distinctive relationship to that member of staff (and the longevity of the matrons' involvement in their care).

Patients frequently remarked on the value of their matron's interest in them as unique individuals. They explained this interest as a result of a matron being dedicated to her patients, enjoying her work with them or working with a vocational calling to help others. Thus one patient commented that her community matron was "the most caring person I have ever met"; another observed her matron's "devotion to patients so that she must enjoy the work"; and another noted that her particular matron "gives 120% to her work, it's more that a job, it's her whole life!"

Patients often remarked on the contrasts between the community matrons and other community and primary health care staff who "can't be bothered", "just push you off", "don't care", are "not professional" or "not caring". However patients were not cognisant of the varied work performance demands of staff in different services patient, most notably that community matrons managed case loads that allowed them to often dedicate an hour to a single patient visit. Several patients interviewed felt that staff must "love their job" (32001) because they are "so professional" (32024) and dedicated to their patients.

The emotional attachment or dependence that some patients developed for particular community matrons was highlighted in the course of interview and observation work. Thus one patient noted that "she is the person who gives me a focus or goal for getting better… she's the person [who] I eat for" (32006), another patient described her matron as "another limb" and another's daughter remarked that "I don't know where she would be without her now, she just such an important part of her life" (32000).

The intense interpersonal ties of patients to matrons could be further complicated by some matrons' often confidential advisory and emotional support work with relatives and informal carers.

For example, one matron learned of the complex marital and medical history of one of her patients following an unplanned discussion with this man's wife

during an afternoon visit and this information remained confidential from the patient but important to his care management. In some situations the work of the matron and ward administrator was the ongoing support of informal carers. Thus one patient explained,

> *"when my husband said "I just don't know what to do anymore" She was there for him.. she said "if you want to get in touch you phone me up, which he did several times and she came out to us" [in fact this emotional and practical support had been more frequent and confidential that this patient knew] (32008).*

The upkeep of long, intense and (from some patients' perspective) highly personalised relationships of care and assistance had an inevitable counter side for both staff and patients. It is, perhaps, inevitable that exceptionally high patient expectations of knowing and felt connection are difficult to sustain. For example one patient remarked that it is reassuring to know that "she comes for me and is always there, I can always contact her.. always and whenever" (32001) and another patient spoke of his surprise on learning that his matron had taken a weekend off.

Some patients found it difficult to remember the role of the matron and, particularly to differentiate her role as care manager to emergency response work. For example one patient reported their disappointment with their community matron when. Several months previously, her family had called the matron one mid morning to help put her back to bed. The patient (who was morbidly obese) had fallen onto the floor and, although unharmed, was unable to lift herself back to bed. The family (all present) had called the matron to do this lifting and, when she visited, she advised them to contact emergency services who had taken several hours to arrive.

The case management of patients with complex emotional, social, and mental health needs, along with the intensity of patient and staff care relationships over time, also complicated reported patient experience in this microsystem. For example, during the fieldwork period one matron was facing a particularly difficult complaint by a relative of clinical negligence. The incident, that occurred in her absence and arose from some miscommunication between the patient and another community matron acting on her behalf, resulted in the hospital admission of the patient. The relative's complaint became highly personalised, involving correspondence about the matron to various primary care and hospital staff in addition to a solicitor's written threat of a restraining order against the individual matron.

Staff wellbeing

Patients' demands and job demands

The matrons and the ward administrator interviewed remarked on their felt satisfaction or enjoyment of working with patients for extended periods of time ("you get to know what makes them tick" (600; 608;611;609)). However field observations suggest that, in their daily work, staff were more ambivalent about the demands of this patient care work. For example after especially demanding visits (which could easily outlast the hour and be a repeat of all conversations from the previous visits) matrons sometimes noted their frustrations at patients who "can't achieve what you want [for them]" (611) or "the victims of services that have made them dependent.. but still it's hard" (600). One matron explained her reasons for wanting to leave her job because she was "tired of climbing in and out of her car to get to see the patients every day" (608) and another talked of leaving because the work with patients "like this drags you down in the end" (609).

Also, because individual staff invested time and energy in fostering exclusive relationships of trust and care, patients' complaints and negative judgements were often personalised and hurtful: a complaint could feel "horrible, shocking.." (613). Often the gradual withdrawal of case management time from a patient was taken as a sign of impoverished care and several staff were aware that, for some patients, any reduction in the intensity of their support resulted in an emergency services call. Three staff interviewed (600;608;609) noted that patients, more or less consciously, exercised great control over their care within this service because they often called emergency services or arrived in the emergency admissions unit when they felt unsupported by their particular matron (for example when she went on holiday).

Nevertheless the staff survey for this microsystem indicates that staff reported job demands were the second lowest of all the eight microsystems (and second lowest of the community microsystems).

Staff managed these work pressures and frustrations in different ways, depending on their skills and training in workplace behaviours and stress management (in previous places of employment). For example, one matron ensured that she "prepared" herself' for each patient visit (600) (making "emotional 'space" (600) between visits or between patient visits and sometimes difficult negotiations with other health professionals). This strategy was less available to staff without this expertise or who worked part time with a similar patient case load. It is also notable that staff drew on previous employment and skills training to manage work pressures within this service and so the techniques that they used were highly individual and apparently not shared with immediate co-workers.

Staff managed as individuals without felt supervisory support (in the staff survey this microsystem scored joint lowest for felt supervisor support).

Additionally, as indicated above, matrons managed their wards, rather than their individual patients, very differently. Some matrons always avoided direct patient care work that involved "going the extra mile" for patients because they felt that this increase patient dependency and undermined the function of the service. By contrast, other matrons engaged in extraordinary degrees of discretionary care behaviours related to patients (for example attending birthday parties or visiting other services with patients).

<u>Shared Service Goals and Diffuse Job Demands</u>

Work in this innovative community nursing service also included continuous improvement activities for the sake of patients as one important element of in-role work performance rather than contextual or discretionary patient care performance. The nature of work in this innovative community nursing service explains the anomalous staff survey findings concerning staff reported functional performance, relational performance and continuous improvement and helping behaviours within this microsystem.

Interviews with eight matrons and observations of their work indicated that, beyond the agreed primary overall function of the service (to prevent hospital readmissions), the philosophies and practices of matrons were highly varied between individual professionals. Thus some community matrons managed patient care by frequent visits and intense interpersonal support as well as service coordination and other matrons kept more attenuated educational and advisory patient relationships to enhance gradual patient independence.

Additionally, staff interviews and observation fieldwork indicated that work behaviours that might be considered discretionary care behaviours that involved patient helping behaviours beyond job requirements were not clearly or collectively agreed within this service. That is, some staff viewed such discretionary behaviours as part of either functional or relationship in-role performance while others did not. It was, perhaps, for this reason that these service staff, who also experienced a high degree of job control, reported a lower level of job clarity compared to the other microsystems.

Fieldwork observations indicated the competitive edge to matrons' individual working practices that (in the unforgiving organisational climate of 2010) became a focus of division and tension within the service team. Matrons in less full wards noted that various patient demographics across the service areas were "unfair" or "uneven" (they were unable to attract so many patients on their case lists) while matrons with busy wards commented that some other matrons misunderstood the distinctive quality of the service innovation and how to attract patients to the service. Matrons in less buoyant sectors of the service (with less patient 'sign up' or more patient complaint) were less enthusiastic about the development of the overall service. In addition, matrons

who sought to promote patient independence were considered less caring by patients and received fewer compliments.

Field observations indicated that, although this service involved a very small staff team of professionals with a variety of different skills, some matrons seemed reluctant to often seek advice or assistance from their colleagues within the service (and from co-workers who were not their immediate 'work buddy').

<u>Organisational Climate and Local Work-Group Climate</u>

All but two staff interviewed spoke of their unhappiness and disillusionment at work and cited various and often interconnected difficulties in the workplace caused by an unsupportive organisational or service management climate. In all, at interview the matrons and one ward administrator noted five central issues that illustrated or explained their feelings about work.

First, they noted the ongoing and inherent demands of working in a 'cutting edge' service. Staff commented on the stress or exhaustion of always working against established roles and structures and of "feeling under attack" (608) and "always put down" (607) or "blamed" (611) by other health professionals (particularly in primary care and mental health services) who misunderstood their role as care managers.

Second, staff noted the poor recognition of these inherent work demands by organisational and service managers. Staff spoke of a felt lack of support and belonging (to the organisation). Some matrons felt that the service and the organisation devalued its entire staff while other matrons felt that their managers simply did not understand their service. All staff noted that the service has passed through a succession of management styles, from the "disciplinary" to the "patronising" to imposed "self management" (all staff described this) in less than a year. A quick succession of service managers also worried staff who relied on flexible work arrangements with an informal agreement of 'give and take' to maintain a home/work balance. They felt that such arrangements were thrown into question each time a new Head of Service was appointed (608;603).

Third, and more specifically, all staff had been or remained offended by the interpersonal behaviour of many service or organisational managers. For example, two community matrons noted "there is no sense of belonging here... we are just told what to do" (611, 613) after they indirectly discovered that all clinical supervision booked for the team was cancelled with immediate effect and, as important for them, without them being notified. The poor recognition of health professionals as people was frequently noted in examples of service and organisational managers who "completely ignore you outside meetings" (608); "can't even say hello" (611) and "don't know anything about you" (613). Most staff working in this service drew contrasts between this

employing organisation and previous employers, who had been more supportive and engaged with their employees.

Fourth, all staff noted a felt lack of support between colleagues working in this service. Matrons felt aligned to their immediate 'buddy' and ward administrator rather than by the wider service team, who they felt to be "poorly attuned to one another" (607) or "divided" (611). Two matrons complained bitterly of their colleagues' felt lack of emotional support when they had faced difficulties at home and had mentioned them at work. All staff complained of a varied range of hostile, unsympathetic, uncaring or difficult personalities in the workplace. Additionally, observation fieldwork indicated that, between the community matrons, lunchtimes were not sociable times within the community team office[3]. Staff worked on their computers or talked to their immediate 'buddy' who sat next to them. There had been several complaints from some matrons that the younger ward administrators were too 'talkative' and 'gossipy' in the office.

While survey findings in this microsystem indicate that felt local work-group climate was more supportive of high quality patient care than organisational climate staff opinion was quite divided. Field observations suggest that staffs' view of co-working did not extend beyond their individual 'buddy' and their ward administrator (that is, colleagues were often overlooked as co-workers).

Despite these strained co-working relationships an additional source of dissatisfaction of all ward administrators and some community matrons was the physical relocation of the service from a central office area into separate 'ward' offices in primary care service locations. Some staff opposed this move because they felt that they would miss important collegial support and argued that this would prolong their journeys to and from work. Some community matrons saw these relocations as an important service development opportunity.

An important aspect of the felt lack of staff support by the organisation and the service manager was the recent withdrawal of clinical supervision and action learning for staff in this service. This experience might have been reflected in the staff survey findings of staff reported lack of clinical skills and competence to meet job demands (that was the lowest reported for all the eight microsystems) despite these staff having the highest level of professional educational qualifications within the eight microsystems. Also, noted above in the survey findings felt supervisor support was the lowest reported in the community microsystems and joint lowest in the eight microsystems. The felt lack of skills and lack of supervisory support in this

---

[3] Field observations did not include the observation of team meetings or service meetings because staff could not agree to the researcher being present at these

Project 08/1819/213

service might have been exacerbated because of a felt lack of job clarity within this innovative community services.

Looking to the Longer Term....

As indicated from the staff interviews and indicated by the limited staff survey findings, staff in this service felt that neither felt job control (the degree of discretion and autonomy that staff had in making job related decisions) or the availability of time for patients (a resource that is often lacking in patient care services) are sufficient in themselves to support staff satisfaction at work.

All community matrons experienced a situation where there was high felt job control as one where there was a lack of job clarity. The staff reported levels of felt job clarity in this microsystem were lower than for any other of the eight microsystems. In addition, while the organisation continued to make certain tangible resources available to staff to support their job demands (notably higher education training) staff still felt unsupported by the organisation and by their successive service managers. Staff gauged felt organisational climate in terms of interpersonal behaviours and attitudes and degree of compromise of individual managers rather than simply in terms of the tangible resources made available to them.

Overall professional staff talked of 'hanging on' (608;609) and 'just getting by' (611) because they felt that they received excellent pay for the work that they did as well as exceptional professional development opportunities (including funded Masters study). Part time community matrons, along with ward administers, also noted the value of flexible work hours, the convenience to work close to their homes and early retirement plans as reasons for not leaving the service.

In mid 2010 (just after the fieldwork period) one of the most dynamic and ambitious community matrons (who had been involved in the initial service pilot and remained active in promoting the service to outsiders to the organisation) left the service and the organisation. She told the researcher than she had approached a senior manager in provider services about her career progression through the organisation and was told to "not bother for the next four or five years" (600). The following month she had taken a more senior position in a different organisation and the post that she left was frozen. It was this staff member who had once noted that the worse thing for a patient is to suddenly lose their matron or their matron service.

Larchmere Trust: Rapid Response Team

How service design influences staff opportunities to practice patient centred care

Summary

This case study was sampled as a low performing microsystem in a high performing trust. This Rapid Response Team in Larchmere Trust illustrates how service function and design can affect both staff wellbeing and patient experience. Staff survey findings in this microsystem allow only a limited examination of the JR-D model and COR theory. However staff interview and field observations support COR theory. These qualitative findings indicate the ways in which professional staff sought to insulate their interactions with patients from the emotional strains of high job demand and of role stress. These findings also indicate significant informal situations where junior health care professionals drew on the specialist work experience and skills of other team members in order to better manage role stress.

This clinical microsystem also demonstrates how poor service design resulting in poor job control and poor job clarity for staff generates work stress. For qualified staff in particular, poor control over patient care settings and practices affected them personally, causing feelings of guilt, and undermined professional credibility. The qualitative findings highlight the particular strategies used by staff to manage the effects of role stress or to limit the effects of work stress on patients. While care assistant teams sometimes sought to manage work demand by limiting patients' care options, professional teams sought to manage felt work stress by turning towards trusted team members who had the particular skills to advise co-workers on work stress management. Professional staff also adopted active strategies to insulate their felt work stress from their patients. Patient interviews and fieldwork observations indicate that, at least in the short term, these team-focused and individual stress management strategies were effective. This microsystem study also illustrates the complexity of factors that shape patients experience of services delivered in a variety of care settings and in tandem with many other services.

Project 08/1819/213

"Left without a Safety Net": complaints and confusions in a 'rapid response' rehabilitation service

The Head of Adult Community Nursing Services felt that the difficulties of providing good patient care and of keeping good working relations with staff outside of this service were the result of inter-professional working within the service. She felt that holistic patient assessment and care review was a professional nursing task that could not be assigned to allied health professionals. She wondered if professionals within this service were especially defensive about sharing patient assessment and review information. She surmised that poor patient care and experience, along with staff unhappiness and frustration, was rooted in the tensions of inter professional (rather than interagency) working. This manager described the obvious dissatisfaction of professional staff, and particularly allied health professional staff, within this RSS. She noted that they were "very vocal at meetings" and "talked a lot to others [in the organisation]". She found her own position, in attempting to work with staff who "always feel threatened" and "unvalued", very difficult. She felt that this situation had become more difficult since senior stake holders in the service, and particularly service commissioners, had become involved in RSS reform initiatives.

Several months before the research was initiated the RRS manager (and original pioneer of this innovative community health service) resigned following an extended period of sick leave. This manager's unexpected and unexplained resignation left the RSS team (and particularly the professional staff in the team) feeling unsupported during an especially difficult time (see below). During the research period no organisational manager discussed or explained this resignation with the RSS team. Qualified staff in particular spoke of this manager as the "backbone for the service" (601) and said that they had "lost the safety net" (625). At this time several professional staff had recently been the subject of internal or external investigation following patient complaints of clinical negligence. Some of these investigations remained extant and were not concluded during the research period.

Also during this period a newly appointed Deputy Head of Adult Community Nursing Services was charged with the overall service management of the RSS and with implementing a series of programmes of clinical practice training for unqualified staff (nursing and rehabilitation care assistants). Around the time of the research the qualified RRS staff (sometimes represented by this service manager and sometimes not) were involved in ongoing service monitoring and service revision planning meetings with a range of organisational managers and service commissioners.

Service organisation: "we just can't be everywhere at once…" (601)

All RRT staff operated from one office base where, twice or three times, ongoing patient care work and visiting schedules were planned. Just before the fieldwork period the RRT acquired more office space which led to an enhanced

Project 08/1819/213

informal division between professional staff (who occupied the 'computer desk space') and the unqualified staff team (who worked in the room with the large whiteboard for shared work planning). Professional and unqualified staff work activities tended to overlap more often during patient visits in the residential and care homes. Because there was a chronic shortage of professional staff cover within the RRT, a particular work stressor for professional staff was their inability to establish or maintain a strong and consistent presence in the residential and nursing homes where patients were living. This situation was complicated further because care staff working in the residential homes were not all part of the RSS. In effect, RSS qualified staff were professionally responsible for patients but were unable to manage or to effectively supervise all staff who were caring for these patients.

Patients admitted to the RSS were expected to be discharged from the service within six weeks. Some patients progressed from residential to domiciliary rehabilitation support and other patients moved from this service into local authority or nursing home care (a move that incurred financial cost to patients or their families). Many professional staff in the RRS described that they often felt pressurised by patients or their families to make professional care decisions that would not leave families at a financial disadvantage.

During the field research period professional staff absentee levels were relatively high (at 15%). This was booked sickness and maternity leave (for which no locum cover was provided). Despite felt job stress by professional staff in particular (see below) these staff were rarely absent due to unexpected sickness or due to work stress. It is also notable that many of the younger professional staff drove round distances of over two hours between work and home each day. The said that they continued to work in this service because it offered them interesting work; they enjoyed working with particular colleagues; and they would find it difficult to find equivalent work (paid at Band 6 or Band 7) at this point in their career or close to their homes. Some staff, qualified and unqualified, noted that they valued the work autonomy of community rehabilitation work and the staff survey high rating for felt job control reflected this view. However interview and observational fieldwork indicates that staff survey ratings of very low job demand (the lowest of all the eight microsystems) reflects the particular work experience of unqualified staff working as rehabilitation assistants. The qualitative research findings indicate that very low rating of job clarity in this service (the second lowest of all the eight microsystems) was a common experience for all staff in this service and was the product of the inherent tensions and overlaps between patient care and rehabilitation work.

Patient experience

Given the work challenges faced by staff - and as might be expected on the basis of JD-R and COR theory - patient experience reported by patient survey in this microsystem was surprisingly high. Also given the recommendation of this service (as one that was poorly performing in terms of both staff wellbeing

and patient complaints) it is notable that the RSS scored higher on overall Picker and PEECH patient survey scores than all other low performing microsystems (4) and higher for Picker scores than two other high performing microsystems (both in acute services). The PEECH findings for this microsystem indicated high scores items of 'knowing' and 'personal value'. These were the second highest scores for all microsystems (and it is notable that the first highest scores were also from the Larchmere community service organisation). The PEECH scores for 'connection' were lower. As examined through interview and observational findings (below) this might be related to the lack of consistency of staff involvement as patients travelled though this service. Overall, however, the qualitative research findings point towards the poor reliability of our survey data on patient experience where care is delivered in various settings and overlap with many other services[4]. The discussion below examines how such variations are experienced by patients.

"Being in a nice place always makes you feel better" (42004)

Qualitative research findings indicate that the most important variant of patient experience in this service was the wider social and physical environment within which staff gave - and patients received - care. For example, observational fieldwork of staff and patients in one very popular local authority residential facility found that all patients were also very positive about the staff who provided their nursing and rehabilitation care. When patients were asked about the staff who cared for them they talked about their experiences of the residential facilities, noting the "good atmosphere… where everyone makes you relaxed" (42016). In this facility more patients (than in the other facilities where patients were interviewed) complimented the staff (both RRS staff and care home staff) for their patience and encouragement of them (42600; 42005; 42006; 42004; 42007).

For elderly patients in particular, a general impression of being "comfortable" [with staff] (42016) and "being treated how you would like to be treated" (42006) shaped their experience. Some older people mentioned that they found it too difficult (or felt it unnecessary) to remember which staff came from which services and which staff did some things and not others. These patients talked of a general and overarching experience of good care (comfort and gentle encouragement) however they often picked out a couple of staff who they knew better (because they had discovered something memorable about them rather than because these staff had taken a particularly distinctive part in their care).

In those residential and nursing care homes that were less popular with patients both patients and their relatives were more likely to report a poor experience of care by both care home staff and visiting RRS staff. In these care settings patients commented that "they have no choice but to be here"

[4] It is notable that field research with RRS staff and their patients in one nursing care home was discouraged by the acting manager and no patient interviews or patient survey were conducted here.

(42001a); "were here under duress". They also remarked on "disinterested and uncaring" staff (42019) who were "ignorant" (42007), "cared in the only way they knew" (42001a) or lacked any awareness of the chronic illness conditions (42015). Repeated field observations and informal conversations with patients in these less popular residential facilities indicated the effects of care settings on patients' experiences of care practices. During and immediately after observational fieldwork with patients and staff in these care settings patients felt very positive about their interactions with the RRT staff. Many patients stated that they valued or enjoyed this rehabilitation care and several patients felt that they should receive more rehabilitation care from the RRT staff. However those patients in poorer core settings often forgot to acknowledge the distinctive contribution of these staff to their care and, within a few hours, were less able to distinguish good events of care from more general feeling of poor care. In this respect, then, patient experience of care was always coloured by a more general impression of staff and the care setting.

Observational and interview work indicated that patient experience of care in domiciliary rehabilitation services also often varied according to a patient's family situation. All elderly patients living alone felt very appreciative of this service even though field observations indicated that some patients were treated in ways that were very unnecessarily rushed and undignified. In contrast, younger and more articulate patients with concerned informal carers were often critical of their care by visiting health assistants. They were offended when these staff gave unsolicited advice on health and safety in their home as well as when these staff informed them of important changes in their care plans (such as their discharge from the service).

Patient Experience (2) "you can just be waiting for things really …."

By the nature of their health needs, patients admitted into the RSS were facing a series of emotional and social strains associated with the experience of rehabilitation care or unanticipated nursing care. Patients in this service were often at a 'crossroads'. Their own or their family carers' health needs had suddenly altered and this often raised questions about future life plans, including care home accommodation and its financial implications. In addition, younger patients in particular were often frustrated by what was felt to be a slow progress to recovery. Thus one younger man complained of staff offering him only 'slow' or 'occasional' exercise programmes so that "it's as if they [staff] are doing nothing for me" (42016). Although most patients were aware of the reasons why their progress to recovery was slow, the feeling of 'nothing happening' was more often explained in terms of service or staff inefficiency rather than in terms of the slow and uncertain progress of some illness conditions. Similarly, one patient spoke of his frustrations of being "stuck" in a service that "focused on the minute [rather than] the long term" (42007).

At the same time field observations indicated that, particularly towards the end of patients' stay in the service RSS staff were looked to as important 'gate

keepers' to new services and, sometimes, new service entitlements. Professional RSS staff were sometimes criticised as being uninvolved in the care of patients though these important social and emotional transitions (while other patients and carers resented their involvement (fernleept2). In all, comments scattered through patient interviews and various field observations indicate that especially towards the end of their stay in the RSS, qualified staff were less likely to involve themselves, and patients, in important decisions about their future care[5]. The felt limited involvement of qualified staff and patients together in care planning for discharge was sometimes explained by staff to be the result of job demands (particularly the top-loading of RSS work to admission and first assessment). Also, some qualified staff indicated that they were more wary of engaging with patients or carers about discharge plans because "you just end up in the middle of things" and "they can all turn around and put you in the firing line". These staff indicated that their experiences of patient complaint events and investigation procedures had left them suspicious of all patients and relatives and made them reluctant to offer more information or emotional support than was absolutely necessary during this time (that is, staff placed careful limits on their discretionary care work).

Field observations of unqualified staff with patients in care home and domiciliary settings indicated that all staff took great care in their personal interactions with patients (they always introduced themselves, talked to patients by name, and remembered a joke or comment from a previous time spent with them).

One afternoon two rehabilitation assistants together explained to the researcher how they had learned to manage the demanding and often overlooked patient care task of moving into and through a day room full of elderly patients "with all eyes on you" (606) while trying to attend to one elderly patient at a time. They showed the researcher how they had worked out how to move between chairs so they did not appear to be ignoring anyone and how they had found it best to engage patients in one each others' care by encouraging them to congratulate each other on their daily progress.

Despite some care assistants' great care in face to face relationships some unqualified staff lacked a more critical view of patient care and patient experience. For example fieldwork of domiciliary care (over three shifts) included observation of a situation where an elderly patient was readmitted to a care home against his clearly expressed wishes because he had one episode of diarrhoea during his 'trial at home' time[6]. The care assistant team leader appeared to take the decision to readmit this man in order to lessen the work burden on her staff who, she emphasised, did not undertake personal care work. Also in domiciliary care services there were several observations of care

---

[5] Weekly meetings were held in all care homes to review patient progress and these were attended by the RRT staff member usually working in that home.
[6] Such decisions, also made without consultation with qualified assessors or professional staff within the service, were possible because they involved the movement of patients within the service rather than across services.

assistants who ignored the personal or private boundaries of domiciliary care work and so upset younger patients and carers.

"She was a lovely girl but I only saw her once…"(42007)

As noted above, residential patients often found it impossible, or unnecessary, to differentiate between staff arriving from different services. Although RSS staff often told patients and carers how to identify them (by their distinctive purple uniforms) patients and carers often forgot the colour code or were confused by different shades of purple used by different bands of staff.

In addition to frequent confusions over where staff were from (and why they were there) patients sometimes remarked on felt discontinuities of communication, with "different people always asking me the same questions" (42007) as they passed between different specialist staff during their stay in the service. While patients and carers often explained that they understood the necessity for specialist referrals (and many valued these interventions) they could not understand why different specialists asked about the same things. The patients and carers who noted felt discontinuities in communication within the service or across services or across services (42007; 42008; 42016;42013;hbxxo) were also sensitive to the constant changes in staff who assessed or delivered their care, with "too many different faces coming and going" (42007). Two 'expert' patients (who had used a variety of rehabilitation services over several years) were very positive about the interpersonal approach of qualified staff and some rehabilitation/care assistants from the RRT. These staff "make you feel comfortable... work in a quiet way" (42007) and "took the effort to get to know my pace and work with it".

Staff experience

"Everyone is against us" (42625)

All qualified staff in the RRS (except 3 nurses who did not participate in the research) felt that their service had been devalued, unfairly scrutinised or 'scape-goated' by the service manager, organisational managers and service commissioners. As significantly, they felt misunderstood and undefended by Head of Service. They were deeply distrustful of an organisation that they felt was "setting us up" (610), being "misleading.. to run the service down" (613; 617; 618; 621; 625) or working to "some hidden agenda" (617).

During the research period meetings between the senior front-line staff of the service and managers were reported to be very difficult affairs. Staff who attended these meetings returned to the office areas, as well as to their more junior colleagues, clearly distressed and angry. Given the observed and reported effects of tension between organisational and service managers and frontline staff the staff survey findings are surprising. The staff survey rating for perceived organisational support for work was high for this microsystem. This anomaly might be explained by the percentage (50%) of unqualified staff

and some assistant practitioner staff who responded to the survey. These responses indicate that the work stresses generated by management interventions in service reform as well as by some senior professionals' face to face negotiations with managers are not necessarily shared and commonly shouldered by the staff team.

This feeling amongst many professional staff of being scape-goated by managers was exacerbated by the particular design of this RRS as well as by the inherent challenges of interagency rehabilitation work.

As noted above, qualified staff were professionally responsible for the care of patients who were placed in care homes where these staff had limited physical presence and exercised little practical authority. Qualified staff shortages that limited the presence of staff in these care homes were considered to lie at the root of clinical negligence in these homes (for which individual professionals in the RRT had been held accountable). During field observation it was noted that staff regularly scrutinised the staff rotas for evidence of any release of additional locum or agency staff funding. Such evidence would not simply have helped job demand through the working week but would also have been a sign that the managers recognised some responsibility for past events of poor patient care. Additional job demand pressures were felt by qualified staff responsible for holistic patient assessment within the 24 hour 'rapid response' time frame. It was not uncommon for a weekend work shift to involve five patient assessments (with each assessment with a patient taking one hour and the record keeping taking another hour or more). Informal conversations with qualified staff undertaking patient assessment work indicated that often staff found this high and unpredictable work demand less frustrating that the experience of "never following a patient through" (601). Thus some staff complained of the frustrations of "never following things through" (42602) and "never seeing a patient outcome [of my work]" (42618). These staff felt that their job satisfaction was reduced because they were not able to see the results of their care assessment and planning for a patient. In addition many said that they always felt worried because they knew that they often neglected regular care reviews in order to complete patient holistic assessments on admission within the stipulated time frame.

Given this situation it is surprising that the staff survey results in this microsystem showed the highest staff rating for felt organisational climate of patient care than all other microsystems (3.75; mean 3.51). This figure might be explained by the inclusion of staff who did not work in this organisation (but who worked in this service) in the staff survey. In addition, this figure also indicates the highly varied nature of work experience between qualified and unqualified staff (where the minimum rating in this microsystem was 1.83 and the maximum rating was 5.00).

A range of work-related demands on staff - over which they had little control - were also related to the particular design of this RRS. These included:

- *Managing Telephone Enquiries for Staff in Other Services*

Patients were often considered for admission the RRS following an informal telephone discussion between staff from another service or organisation and a qualified member of the RRS team. Observational fieldwork found that these telephone discussions (that one senior staff member estimated to number over 300 a month) were often emotionally demanding times for RRS staff. They had to gather sufficient information to decide on the suitability of their service to a patient who they had not met. They also often suspected that staff from other services or organisations attempted to 'pass on a patient' as quickly as possible. During the research period it was common practice for staff to hover behind one another and act as a 'witnesses' to telephone conversations about new patients. All RRS qualified staff were aware of previous complaints from staff in other services about their being uncooperative or rude towards them. These RRS staff also knew that any decisions to refuse to admit a patient to the RRS, because they judged it inappropriate for a patient, could be questioned or challenged by service or organisational managers.

- *Limited Control over Patient Care Settings*

One particular issue that affected both patients and staff was the felt quality of care home environments[7]. The limited control that staff could exercise over this environment of care was a source of great frustration for some qualified staff, particularly when such care settings were very poor.

Two nursing home establishments in particular, were known by qualified staff, and perceived to be inadequate physical environments for patient care. Field observations included one nursing care home where elderly and sometimes confused patients lacked basic personal amenities (a clock and a mirror) and spent hours alone in rooms behind closed doors (because open doors constituted a fire risk). In this establishment corridors and public areas were filthy and the dining area was inaccessible to less mobile patients. Also in this care home qualified staff found it difficult information on patients from care home staff and there were no facilities for staff meetings and record keeping outside of patients' bedrooms.

Field observations of the second nursing home identified very apathetic and de-motivated care staff as well as many patients and relatives who were angry about their own poor care or the poor care of more vulnerable patients. In this second care home a CQC investigation of another patient unit had identified poor and inadequate care; so the local authority did not place patients there. During this time RRS qualified staff had to continue to place patients in this home as well as give patients and family a 'covering letter' explaining the findings of the CQC inspection.

---

[7] These care home beds were purchased by contract with PCT service commissioners

Project 08/1819/213

In all, RRT staff responsible for patient assessment, placement and care review felt unable to manage or influence poor patient care environments. These staff said that they felt "embarrassed", "guilty", "terrible", "powerless" and "mentally drained" (610;613;617;618;621;625) because they placed patients in poor care settings[8].

In addition to qualified staffs' feeling of poor job control dues to the poor design of the RRS, extra-service work demands also led to role stress and personal anxiety. These included:

- *Not Being Heard by Managers*

During the field observations a series of events proved especially significant for shaping the experience of work in this RRS and Larchmere organisation amongst qualified staff. When seeking to engage qualified RRS staff in service development, provider service managers requested that they map their service and work together to establish revised criteria for patient admission and discharge criteria. The RRS undertook this work with great energy and dedication, with several taking on evening and weekend work to submit these for discussion with senior managers in the Larchmere. The same week as these plans were submitted, and during an informal meeting with their acting service manager, the qualified staff team were told that their submitted documents had been physically 'ripped up' at a commissioners' meeting and an alternative service function agreed. Staff felt that their work to develop a service for intensive rehabilitation had been suddenly and unilaterally redefined. At this time several of the more senior qualified staff in the service began to look for new jobs.

- *The Emotional Effects of Formal Complaints and Investigations*

Involvement in formal complaint investigations within and beyond the organisation had a profound effect on staffs' personal and work lives. Staff described that their sleep was affected (617;625), concentration impaired (610;613) and family life disrupted (621;613). Staff who had been through investigation procedures, all senior professional staff who remained in the service, noted that it was the effects of investigation procedures that was often as distressing to them as the effects of the investigation. For example they described the miserable effects of receiving notification letters sent to home addresses rather than their work address; the lack of early information on the content of a complaint and the failure of investigating bodies to notify individual staff of the outcome of investigation findings. In addition, professional staff felt that, in these processes, the search for accountability did not extend beyond individual professionals and that service and organisational

---

[8] Additionally, all staff suspected corruption within a commissioning organisation that continued to contract beds from poor quality private and voluntary organisation providers

Project 08/1819/213

responsibilities for providing adequate job resources (notably adequate staffing) were often sidestepped.

In this microsystem the staff survey (including qualified and unqualified staff) shows a particularly low score for affective patient orientation (which is the lowest of all the eight microsystems) and a low score for work dedication (also the lowest of all the eight microsystems). Staff interview findings suggest that the low score was more likely amongst qualified staff who had undergone patient complaint investigations. As one senior nurse remarked "once you've been through that.. well… you never want to go there again.. and you're just well.. very careful what you say.. who you say it too… you just make sure you are alright… you never really trust any of them again.. well you can't can you?" (xxros).

This view contrasted noticeably with that of some unqualified staff who emphasised their enjoyment from relationships with patients, particularly domiciliary patients who they came to know better as well as from "doing the extra bits" for them (605).

Staff Experience (2) " You have to stop it dragging you down..(610)

The effects of professional work in a poorly designed service; of the poor behaviours of some managers; and of concerns about complaints by patients and staff in other services left staff emotionally raw. During interview and observational fieldwork many qualified staff spoke of feeling "low" (613; 625; xxros;618;616;619) or "down" (610;626) at work. They felt that both their work and their service was not valued by managers who "only tells us we have a terrible reputation" (618;621;625).

The emotional effects of professional work were not hidden by many individuals in the RRS. All qualified staff remembered times when they had comforted distressed senior colleagues who had just returned from especially difficult management meetings. During such times staff shared numerous tales of felt injustice. At the same time those qualified staff who felt discomfort when shared emotions "ran high" (gno.) avoided office times and spaces where irate colleagues gathered.

A notable aspect of staff wellbeing in this service is the capacity of most qualified staff to reflect on and to attempt to manage work stress in informal and collaborative ways. Many staff explained the reason for trying to manage negative feelings about work was to protect their face-to-face work with patients and carers. Their common strategies to manage work stress included:

- *Managing emotions in changing work spaces*: June, a senior occupational therapist noted, "patients don't notice the stress and anger...we keep this here at base [the office]… when we leave here we put our profession hats on" (610). These comments indicate how some staff tried to separate

their feelings about work from their behaviour towards a patient by exploiting the physical distance between patients and 'the organisation'.

- *Informal mentoring*. The capacity of qualified staff to manage work stress appeared to vary between more or less experienced staff. More junior qualified staff regularly looked to a more senior colleague (and usually someone from the same professional background) as an exemplar in managing good relations with patients and carers. During the research period a series of regular meetings were organised by different professional or working groups within the RSS team to support work and career development. These groups also became important forums where more personalised work support relationships were fostered and informal mentorship ties established.

- *Looking to particular experts in the multi-disciplinary team*. In this complicated and demoralised service, less experienced qualified staff often struggled to manage their emotional investments in patient care: "it sometimes feels all too much…then I rush about and get irritable because the right things haven't happened at the right time… and patients pick up on that" (625). Several of these staff had looked to the senior mental health nurse practitioner for advice on managing in the workplace.

- *Drawing closer to some colleagues*. Many staff (and particularly allied professional staff who felt most undermined by felt service changes) felt that "I only come to work these days because of my colleagues" (610; also 613;621;625). Throughout this time of great unhappiness within this service almost all staff remained loyal and defensive of 'their' service, often noting the various service awards and positive external evaluations achieved in previous years and reminding the researcher and each other of the importance of the service vision and of the need for improvements.

Project 08/1819/213

References

1.   Cooke R, Lafferty J. Organisational culture inventory. Plymouth, MI: Hughman Synergistics; 1987.

2.   Organ DW. Organizational citizenship behavior: The good soldier syndrome. Lexington, MA: Lexington Books; 1988.

3.   Podsakoff PM, MacKenzie SM, Paine JB, . DGB. Organizational Citizenship Behaviors: A critical review of the theoretical and empirical literature and suggestions for future research. Journal of Management. 2000;26:513-63.

4.   Bateman T, Organ D. Job satisfaction and the good soldier: the relationship between affect and employee citizenship. The Academy of Management Journal. 1983;26(4):587-95.

5.   Organ DW, Podsakoff PM, S.BMacKenzie. Organisational citizenship behaviour: Its nature antecedents and consequences. Thousand Oaks: Sage; 2006.

6.   Burnes, Pope R. Negative Behaviours in the Workplace: a study of two Primary Care Trusts in the NHS International Journal of Public Sector Management. 2007;20(4):285-303.