

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

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Glossary of terms/abbreviations

ACNS: Adult Community Nursing Services

B&B: Broaden-and-build

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CIPD: The Chartered Institute of Personnel and Development

CMS: Community Matron Service

CNA: Certified Nursing Assistant

COR: Conservation of resources

DoH: Department of Health

EAU: Emergency Admissions Unit

EFA: Exploring Factor Analyses

EI: Emotional intelligence

HRM: Human resource management

IoM: Institute of Medicine (US)

JD-R: Job demands-resources

Microsystem: the combination of a small team of people who work together on a regular basis—or as needed—to provide care and the individuals who receive that care (who can also be recognized as members of a discrete subpopulation of patients.)

M for E: Medicine for the Elderly department

MRSA: Methicillin-resistant Staphylococcus Aureus

NICE: National Institute for Health & Clinical Excellence

NQB: National Quality Board

OH: Occupational Health

OB: Organisational behaviour

OP: Organisational psychology

POS: Perceived Organisational Support

SQ: Service quality

PCPB: Patient care behaviour and performance

PEECH: Patient Evaluation of Emotional Care During Hospitalisation

PPI: Patient and Public Involvement

Presenteeism: individuals attending work with symptoms of illness which have the potential to reduce performance or work-related injuries and stress

QIPP: Quality, Innovation, Productivity and Prevention

RRT: Rapid Response Team

WTE: Whole time equivalent

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Figure 34 'An architecture for understanding the links between the context of work, management of people practices, psychological consequences for staff, staff behaviour and performance, and employee health, performance and patient care in the NHS' reproduced with permission from the former Commission for Health Improvement.

A favourable ethical opinion for Phase I of this research was granted by Cambridgeshire 4 Research Ethics Committee in January 2009, REC reference: 08/HO305/77.

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Key Messages

- There is a relationship between staff wellbeing and various dimensions of (a) staff-reported patient care performance and (b) patient-reported patient experience.
- Individual staff wellbeing is best seen as an antecedent rather than as a consequence of patient care performance; seeking systematically to enhance staff wellbeing is not only important in its own right but also for the quality of patient experiences.
- Patient experiences are generally better when staff feel they have:
 - a good local (team)/work-group climate
 - co-worker support
 - job satisfaction
 - a positive organisational climate
 - organisational support
 - low emotional exhaustion
 - supervisor support.
- Yet working environments associated with high levels of emotional exhaustion (e.g. end-of-life care) or high job demands (e.g. accident and emergency) take their toll on staff even if staff are performing well.
- Our research suggests local climate is critical for staff wellbeing and high quality patient care delivery. Ward/team leaders have a critical role in setting expectations of values, behaviours and attitudes to support the delivery of patient centred care and thus it is important for NHS organisations to:
 - systematically measure and monitor levels of quantitative job demands; invest in unit level leadership and supervisor support and invest more in creating well functioning teams.
- If NHS organisations regularly monitor patient experience (e.g. complaints, real-time feedback) and staff wellbeing (e.g. high sickness absence, reports of bullying or disciplinary issues) this can help them to: (a) target resources to areas that are known to be problematic and (b) disseminate learning and good practice from local teams/work groups that are known to be doing well.

Executive Summary

Background

It appears self-evident that patients' experiences and the quality of health care they receive are influenced by the experiences and wellbeing of the staff providing that care. Associations have been described between job satisfaction and performance and absenteeism of health workers, as well as nurses' job satisfaction and patient satisfaction, nurse stress and patient satisfaction (and in acute care, medication errors and falls). However, much of the evidence comes from North America and methodological weaknesses have been identified. The links between staff wellbeing, affect, motivation and patient care are likely to be multi-faceted. Such links are shaped by the societal and organisational contexts within which interpersonal relationships of care - between staff and patients as well as between staff – occur. They are also influenced by the broader, shifting, and sometimes discordant debates over what constitutes 'satisfying work' and 'quality care' that circulate within different staff groups and amongst individual practitioners and patients. There is limited UK research that explores factors that link staff motivation and wellbeing to patient experiences. The clinical and emotional care needs of patients and their anticipated or actual prognosis have been shown to have an impact on the work motivations and psychological work reactions of staff. Although research to date has shed light on how experiences differ between staff groups, there has been no consideration of how these relate to patient experiences of care.

Aims

In this three-year mixed methods study we explored links between (a) patients' experiences of health care, and (b) staff motivation, affect and wellbeing. Our specific study objectives were to:

1. Identify and analyse attitudes and behaviours of staff described by patients as shaping their experiences that may connect with, and be influenced by, staff wellbeing.
2. Determine which particular staff attitudes, affect and behaviours impact on patients' experiences of care.
3. Explore how staff experience work and how this influences their affect, motivation and capacity to deliver high quality care.
4. Identify how context, including different types of organisational arrangements, culture or climate contribute to staff wellbeing and patient care.
5. Explore with staff the issues of emotions at work, emotional labour and customer orientated care.

6. Identify ways to enhance the experience of patients and the wellbeing of the healthcare workforce.

Methods

We undertook a two phase research process linked to the stated objectives of the study. In Phase I we held two patient focus groups and negotiated access to four - purposively selected - NHS trusts; two in the acute and two in the community sector. We interviewed 55 senior managers from these four trusts to understand their views of staff wellbeing and patient experience and determine any interventions underway in their organisations seeking to improve either or both. In Phase II we selected two clinical microsystems in each of the four case study organisations to reflect different types of care relationships and settings and high and low performing microsystems as determined by senior managers. In each microsystem we undertook a staff and patient survey, staff and patient interviews and non-participant observation of routine day-to-day interactions and of team and care processes. To protect the identity of the trusts we have created pseudonyms for each of the four NHS trusts. The eight microsystems (anonymised) were:

- Emergency Admissions Unit and a Maternity service in 'Oakfield' (acute trust 1)
- Medicine for the Elderly Department and a Haemato-Oncology service in 'Elmwick' (acute trust 2)
- Adult Community Nursing Service (1) and a Community Matron Service in 'Ashcroft' (community organisation 1)
- Adult Community Nursing Service (2) and a Rapid Response Team in 'Larchmere' (community organisation 2)

In total, 498 patient experience surveys and 106 patient interviews were conducted. 301 staff wellbeing surveys were completed at time 1 (and 126 at time 2) and 86 staff interviews and 206 hours of observation were undertaken. We present findings from four of these microsystems in the main body of the report – to highlight the high and low performing case studies in acute and community.

Results

Phase I

Patient recollections of their own - and others' - experiences are vivid, and focus largely on the relational aspects of their care. In our focus groups patients were able to discriminate between 'good' and 'bad' individual staff working within services, on wards or shifts. This discrimination rested on the nature of relational care received and patients distinguished between staff perceptions of their work as a job or as a vocation (and insisted on the importance of the latter). At the same time some patients recognised the influence of the workplace on staff behaviours towards patients: notably,

work in 'heavy' or dangerous service areas, a poor built environment and poorly managed wards. Our data also highlighted patients' and relatives' limited capacity to directly question staff about poor care and poor caring behaviours.

The interviews with senior managers in our four NHS organisations revealed different organisational contexts in which a range of initiatives to improve staff wellbeing and/or patient experience were being implemented. They showed that staff wellbeing was understood in two very different ways: either as a factor that supported organisational objectives and reputation (a corporate view) or the result of patient care work satisfaction, that was frustrated or undermined by organisational initiatives and demands (a vocational view). In either case it was clear that managers appropriated the theme of 'staff wellbeing' to justify and promote longer established views on the purpose and motives for health care work.

Phase II

Our results show there is a relationship between staff wellbeing and various dimensions of (a) staff-reported patient care performance and (b) patient-reported patient experience. This relationship is complex. For example, although our staff survey panel data suggested wellbeing does not appear to have a very strong or clear direct effect on how staff rated their own patient care performance, it does show that staff wellbeing is an important antecedent of patient care performance. It also suggests that wellbeing is affected by employee experiences at work and by individual skills and work orientations. The descriptive statistics from our staff and patient experience surveys indicate seven staff variables ('wellbeing bundles') which correlate positively with patient-reported patient experience. These are:

- local (team)/work-group climate
- co-worker support
- job satisfaction
- organisational climate
- perceived organisational support
- low emotional exhaustion, and
- supervisor support.

Our in-depth qualitative field work across the eight microsystems offers greater insights into these variables. It highlights the adverse impact of high levels of job demand on staff wellbeing, through higher levels of emotional exhaustion and reduced job satisfaction, which impact on patient care. Any positive effects of job satisfaction and positive affect on performance are nullified by high levels of exhaustion. In microsystems where patients rated their experiences as being relatively low we consistently found poor relational care with staff largely failing to 'connect' with individual patients. However, our findings also suggest a win-win situation whereby high levels of patient care performance need not necessarily be achieved at the expense of employee wellbeing.

High levels of job control - as well as key personal resources such as high levels of job skills, competence and work dedication - can significantly help to cushion the negative effects of high job demands on wellbeing. Such

personal resources can also moderate the adverse effects of high demands and exhaustion. Additionally, high levels of social support from supervisors, co-workers and the organisation has a positive effect on wellbeing in that it helps to reduce exhaustion, while also enhancing satisfaction and relative positive affect at work.

Our findings also show that the effect of staff wellbeing on performance depends, at least in part, on the climate for patient care. In particular, our results indicate that a strong climate for patient care particularly at the local (team) level can help to reinforce some of the positive effects of individual wellbeing on patient care performance. Critically, local climate can also act as a substitute for individual wellbeing; 'making up' for the absence of high levels of wellbeing. Seeking systematically to enhance staff wellbeing is, therefore, not only important in its own right but also for the quality of patient experiences.

Implications for practice

NHS organisations should consider how best to:

- Target their limited internal resource in areas that are known to be problematic either in terms of low patient experience (complaints, real-time feedback) and/or poor staff wellbeing (indicated by, for example, high sickness absence, reports of bullying or disciplinary issues).
- Disseminate the learning from those areas that have good patient experience and high staff wellbeing and are known to be places where staff want to work (by, for example, linking specific wards through buddying of ward managers to help challenge and transfer learning from one to the other).
- Enable team leaders to invest time and energy in team building activities to benefit patient care delivery.

In order to enhance staff wellbeing NHS organisations can:

- Systematically monitor levels of quantitative job demands associated with different care environments and where possible limit these as a key way of minimising levels of exhaustion amongst employees.
- Invest in unit level leadership and supervisor support (i.e. ward sister level in acute and team leaders in community) that promotes good team working and supportive peer relations.
- Build teams and teamwork by, for example, encouraging ward managers and team leaders to consider:
 - active team building
 - facilitating greater staff empowerment and ownership of their work through, for example, Schwartz Rounds as one way to create space to talk about the emotional aspects of care work in the multi-disciplinary team
 - developing a local care climate that is supportive for staff but which also sets clear expectations, goals and direction for patient care performance.

- Support ward managers and team leaders to recruit and performance manage staff around the following areas:
 - high levels of job skills and competence amongst front-line employees
 - recruit to organisations' core values to include high levels of work dedication
 - examining attitudes and beliefs in staff and champion continuing and systematic training, development and up-skilling.

In order to improve patient experience NHS organisations can:

- Support staff to deliver relational care: organisations need to enhance staff's ability to engage with patients on a meaningful personal level; this is long term work (and amounts to much more than offering staff a 'script' for patient encounters).
- Invest in staff work environments to ensure quality patient care:
 - optimise patient and carer experience feedback by triangulating from different sources
 - build in opportunities for staff to ask patients and their relatives what staff are doing well and what they could do better
 - invest in unit level leadership and supervisor support to create well functioning teams and to understand the links between ward climate, staff wellbeing and patient experience
 - use tools of acuity and dependency to argue for sufficient staff in relation to the level of need of the patient population.

Our study has also identified wellbeing 'bundles' which would enable organisations to support their staff to deliver high quality care (see 'results' section above).

Implications for policy

The Boorman Review was heralded as a watershed in wellbeing at work for the NHS, yet despite critique from Steve Boorman of Occupational Health (OH) departments, they remain the key mechanism for delivery of much of the staff wellbeing agenda. The characteristics of a new-look OH service have been outlined, including the need for it to contribute to improved organisational productivity. Staff wellbeing as conceptualised and described in our study is about much more than physical wellbeing, healthy lifestyles and individual staff stress, important though these are. It is observed that:

- A broader framing of OH enables staff wellbeing data to be sensitively used by organisational development (OD) departments to enable individuals to proactively support and manage their relationships with other staff and patients.
- OH departments that are adequately resourced and linked to OD departments in trusts mean that issues such as high sickness absence are not tackled in a reactive and punitive way but are seen as a barometer of wellbeing issues that affect care quality.
- OH departments which align much more closely to Trust Boards, are better able to ensure delivery of the clinical vision.

- Reports of high sickness absence are indicative of the context of the local ward/team climate: individual (stress; injury etc); team (lack of support; bullying); organisational and wider contextual issues.
- When such issues are highlighted at board level and measures taken through OD to manage them; our study suggests such a strategic approach to improving staff wellbeing is likely to have a positive impact upon patient care experience.
- An agreed minimum dataset for NHS staff and wellbeing services and the appointment of a board executive champion for staff health and wellbeing could be one way on ensuring staff wellbeing gains greater prominence in NHS trusts.
- Senior leaders have a vital role in enabling line managers to support staff and tackle their wellbeing issues. The mechanism for delivery of this could be local work wellbeing champions that have patient-centred care as their core mission together with high support for staff wellbeing at work.

Conclusions

Our study has found that - with the exception of one of our eight microsystems - where patient experience is good, staff wellbeing is good, and vice versa. Interactions between both organisational and team climates for patient care and individual staff and patients shape the relationship between staff wellbeing and patient experience. Our results suggest that individual staff wellbeing is best seen as an antecedent rather than as a consequence of patient care performance. Thus it is important to invest in and support individual staff wellbeing at work in order to enable staff to better deliver high quality patient care.

Our study has highlighted the importance of the local work climate for staff wellbeing and patient care performance. The importance of the team, and the team leader role in supporting and nurturing staff, in building a strong climate for patient care was evident; local leaders have a critical role in setting expectations of values, behaviours and attitudes to support the delivery of patient-centred care.

Our results have clear implications not only for job design within healthcare organisations but also for the nature and quality of team climates that could be developed and the nature of supportive local leadership and supervision that could be put in place.

The Report

1 Introduction

Associations have been reported between various aspects of staff wellbeing and patient experience. However, evidence mostly comes from North America and reviews suggest methodological weaknesses. This report of a three year mixed methods study which explores the links between (a) patients' experiences of health care, and (b) staff motivation, affect and wellbeing in the English NHS was funded by the National Institute for Health Research Service Delivery & Organisation programme.

2 Background

This chapter is divided in two main parts. In Part I we describe the contemporary policy context (Section 2.1) relating to staff wellbeing and patient experience in the English NHS before defining and discussing these two core concepts (2.2 and 2.3) for the purposes of this study. The discussion of wellbeing includes an overview of the emotional dimension of healthcare interactions which was a central focus in our fieldwork.

We then review a broad literature - from health services research, organisational psychology and behaviour, human resources management (HRM), and the wider organisational and management sciences - to determine:

- The scope and strength of the existing evidence of a link between staff wellbeing, affect and motivation (hereafter referred to as staff wellbeing) and patient experience including an overview of those interventions that have aimed to improve staff wellbeing and thereby may be expected to have an impact on patient experience (Section 2.4).

The literature pertaining to wellbeing - and often associated quality of life measures - is extensive and wide-ranging and we do not aim to cover it all here, rather to give a flavour of the debates and the issues as they relate to the healthcare sector in particular.

Building on and extending the literature review presented in the first part of the chapter, in Part II we present the overall theoretical framework that underpins the study. We focus, in particular, on the basic explanatory model that informed the quantitative part of the research. As part of this analysis we draw on important insights from the organisational behaviour (OB), organisational psychology (OP) and service quality (SQ) literatures to examine key potential antecedents, first, of employee patient care

behaviour and performance (2.5) and second, of employee wellbeing at work (2.6).

The chapter ends with a summary of the findings from our review and a discussion of the implications for our study design (2.7).

Part I: Background Literature Review

2.1 National policy context

The contemporary policy context in the English NHS for this study is shaped by the Black report (2008) (1) and recent NHS Health and Wellbeing review ('the Boorman review') (2). Two other national initiatives (the NHS Constitution and the Quality, Innovation, Productivity and Prevention (QIPP) programme) highlight the crucial role of staff wellbeing in improving the efficiency and quality of health care services. Improving patient experience is central to the new NHS Outcomes Framework. Each of these is discussed in turn below.

2.1.1 Staff wellbeing

In 2007 Dame Carol Black was commissioned by the Secretaries of State for Health and Work and Pensions to undertake a wide-ranging review of the health of Britain's working age population. The aim was to develop a baseline understanding of the health of working age people and its impact on the economy and society. The review published in 2008 (1) showed that work is generally good for people's physical and mental health and identified the importance of healthy workplaces designed to protect and promote good health. It also recognised the role that workplaces can play in the prevention of illness. Relevant to our work, the review noted that mental health problems and musculoskeletal disorders are the major causes of sickness absence and worklessness due to ill-health. The review estimated the annual economic costs of sickness absence and worklessness associated with working age ill-health to be over £100 billion and made a compelling case to act to improve the health and wellbeing of the working age population.

The Boorman review (2, 3) was very much influenced by the Black report and focused attention on the nation's largest employer, the NHS. It was commissioned by the previous Labour government but its recommendations (see Appendix 1) - including that health and wellbeing of staff should be embedded in the core business of the NHS and that health and wellbeing services need to be properly resourced in order to deliver both long-term savings and improved patient care - were adopted by the incoming coalition Government in the July 2010 health white paper.

Such a policy focus on staff wellbeing in the NHS seems overdue given that results from the annual NHS Staff Survey during the period 2003-2010 reveal that self-reported levels of bullying, harassment and abuse from other staff (15% of staff in 2010) and work-related stress (29% of staff in

2010) have remained relatively static. Such proportions are clearly significant in a workforce comprising over 1.2 million people. The Boorman review reported that the average working days lost each year per whole time equivalent (WTE) in the NHS are 10.7 but that there is significant variation in sickness absence rates across the NHS with reported rates ranging from 1.75 to 7.42% across NHS trusts. The direct cost of sickness absence was estimated at £1.7 billion a year, and the review recommended a target decrease of one third, or £555 million. The sheer size of the NHS workforce means that poor staff wellbeing has a significant impact on the public health of the population and on NHS productivity whether through 'presenteeism' (individuals attending work with symptoms of illness which have the potential to reduce performance) or work-related injuries and stress).

The findings and recommendations of the Boorman review were predicated - at least in part - on there being an extensive and overwhelming evidence base to support a link between staff wellbeing and patient experience in health care (although the author of the report noted that '... whilst there may not be cause and effect [the findings are] consistent across a large dataset'). The Boorman team undertook a staff perception survey of over 11,000 NHS staff and over 80% of staff surveyed felt that their health and wellbeing impacts upon patient care, and virtually none disagreed (2). The review found that NHS organisations that prioritise staff health and wellbeing perform better: they have improved patient satisfaction (up to 10% better), stronger quality scores and better outcomes for patients (half Methicillin-resistant Staphylococcus aureus (MRSA) rates), as well as higher levels of staff retention and lower rates of sickness absence.

Common sentiments expressed during the formulation and dissemination of the review's findings included that there is '*plenty of evidence that high performing organisations look after their staff's health and wellbeing*', that '*staff health and wellbeing leads to improved standards of care*', that '*staff are a barometer to patient care*' and that there is a '*clear link between staff health and wellbeing and standards of care*'. Yet in the accompanying staff survey less than 40% of staff believed their service proactively tries to improve staff health and wellbeing. This was consistent with the finding in the Boorman review that:

'in many places the role of staff health and wellbeing services in maximising the contribution that staff make and in helping Trusts to deliver consistent high quality and economical services was overlooked.'

It should be noted that whilst the Boorman review suggests that it is widely understood that the health and wellbeing of the workforce makes a major contribution to the delivery of high quality healthcare (4), beyond the intuitive feeling that this must be so, the report does not advance a theoretical framework to support this assertion, nor explicitly link staff and patient data beyond the organisational level.

There was a clear expectation in the 2009-2010 *NHS Operating Framework* for all organisations to implement the recommendations arising from the

Boorman review and this national commitment has been maintained; to this end, commissioning processes and organisational assessments by the Care & Quality Commission and Monitor have been aligned in order to monitor and support improvements in staff health and wellbeing. One important factor shaping the response from the NHS in implementing these recommendations will be the meanings and understanding that senior managers in local organisations ascribe to the phrase 'staff wellbeing'; we explore this specific issue in Section 5.3.1 of this report.

As well as the Boorman review the contemporary policy context in the area of staff wellbeing has also been shaped by two further major policy initiatives. Firstly, in 2007 the Department of Health, in conjunction with Ipsos MORI, conducted a piece of research, referred to as 'What Matters to Staff in the NHS' (5). The research identified the major factors contributing to staff engagement and motivation to provide high quality patient care. These themes informed the *Next Stage Review* and subsequent four staff pledges in the NHS Constitution which set out what staff could expect from NHS employers as part of the commitment of the NHS to provide high-quality working environments for staff:

- Pledge 1: to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers, and to communities.
- Pledge 2: to provide all staff with personal development plans, access to appropriate training for their jobs and the support of line management to succeed.
- Pledge 3: to provide support and opportunities for staff to maintain their health, wellbeing and safety.
- Pledge 4: to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

The second important policy initiative relating to staff wellbeing, 'Quality, Innovation, Productivity and Prevention' programme (QIPP), is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector. The programme aims to improve the quality of care the NHS delivers whilst making up to £20billion of efficiency savings by 2014-15. The improvements to staff health and wellbeing recommended in the Boorman review - to be implemented with support from the National Institute for Health & Clinical Excellence (NICE) - have been further justified in terms of helping deliver the four elements of the QIPP programme for the reasons argued below:

- Quality: healthier, more motivated staff have been shown to deliver better, safer, higher quality care on a more consistent basis

- Innovation: staff-driven health and wellbeing initiatives have the potential to begin the culture change needed to encourage innovation at all levels within the NHS.
- Productivity: reducing sickness absence will mean more staff are at work, improving morale and reducing stress.
- Prevention: raising staff awareness of how to prevent ill health in their own lives and introducing innovative models for staff wellbeing in the workplace will encourage staff to become strong advocates for prevention, passing on ideas and practice to patients (6).

In support of Boorman and the QIPP agenda, NICE has produced and disseminated guidance related to employees and employers (7) covering clinical conditions likely to be encountered by occupational health providers (for example, 'Promoting Mental Wellbeing at Work' and 'Management of long-term sickness absence and incapacity for work'). However, the first national audit of implementation of this NICE guidance in NHS trusts in England found variation across the country (8); some trusts had successfully implemented many aspects of the six sets of evidence-based guidance but more action could still be taken to improve the health and wellbeing of staff. For instance, whilst mental health problems are the most common health issue reported by staff, only 46% of trusts had a plan or policy to promote the mental wellbeing of their staff and only 63% of trusts provided training for line managers on how to promote and protect employee mental wellbeing. The audit found that trusts that prioritised health and wellbeing at a high level within the organisation had made more progress with implementation of the guidance than trusts that did not report on staff health and wellbeing at board level.

2.1.2 Patient experience

The NHS Next Stage Review led by Lord Darzi (9) defined quality as:

- the effectiveness of the treatment and care provided to patients;
- the safety of the treatment and care provided to patients; and
- *the broader experience patients and their carers have of the treatment and care they receive* (our emphasis).

Reflecting the growing recognition of patient experience as a key component of 'quality', the first NHS Outcomes Framework was designed to serve the wider goal of creating a high quality health system that delivers safe, clinically effective, and patient-centred care. It did so by setting out the outcomes and indicators to be used to hold the NHS Commissioning Board to account for the outcomes it delivers through commissioning health services from 2012/13. The Framework addresses 5 key 'domains' of which one is 'Ensuring that people have a positive experience of care', illustrated by figure 1 (Figure 1).

Figure 1. Five domains of the NHS Outcomes Framework

Domain 1	Preventing people from dying prematurely	Effectiveness
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill health or following injury	
Domain 4	Ensuring that people have a positive experience of care	Patient experience
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety

Source: Department of Health. (2010) The NHS Outcomes Framework 2011/12. London; Department of Health (page 10)

Eight indicators will eventually be in place to help evaluate improvement in this 'patient experience' domain (domain 4). These will assess:

- patient experience of outpatient services
- responsiveness to inpatient needs
- patient experience of A&E services
- access to GP and dental services
- women's experience of maternity services
- patient experience of community mental health services.

Two indicators (to assess end of life care - using a survey of bereaved carers - and the patient experiences of children/young people) still require development.

NICE has been charged with developing 'Quality Standards' to underpin the outcomes set out in the NHS Outcomes Framework. Patient experience, as one of the three elements of quality, will be reflected in all Quality Standards. However, standards are also to be developed specifically relating to delivering positive patient experience either generally or in particular settings or for particular groups. There is strong policy interest in linking payment/incentives to patient experience but there remain important questions as to how a transactional incentive (particularly one at a whole organisation level as typically envisaged) can really influence and deliver improvements in relations between individual people. At the organisational level, we do not know which national policy levers (incentive, penalty, target, market competition, publication of information etc) work best to improve patient experience; this is a relatively 'evidence-light' zone in which to make policy decisions.

The above section summarises key aspects of the contemporary policy context in the English NHS that are relevant to staff wellbeing and patient experience. The link between staff wellbeing and patient experience is sometimes made in policy circles, although it is more commonly referred to in terms of a link between staff wellbeing and 'productivity' (rather than the

quality of patient experience directly) – see, for example, the Black Report and the Boorman Review. Although Boorman and others have sought to explore the relationship between measures of staff wellbeing and indicators of patient experience at an organisational level using routinely collected data (for example, comparing staff absence rates with levels of patient satisfaction or MRSA rates), few studies have sought to explore such links at the level of clinical microsystems or front-line services.

The following two sections provide more detailed descriptions of how we are conceptualising ‘wellbeing’ and ‘patient experience’ in our own study.

2.2 Wellbeing

2.2.1 Defining ‘wellbeing’

There is often an assumption of a discrete and universally shared definition of the term, wellbeing. However, it is a labile concept and policy-maker and practitioner views on wellbeing vary across sectors because they sit within a range of value assumptions. It is often used as an umbrella term, meaning different things to different people all of whom agree that it is ‘a good thing’ but quite what ‘it’ is depends on the context in which it is being discussed. The term has permeated healthcare and, as outlined above, was applied (in terms of wellbeing at work) to healthcare care staff in the 2009 NHS Health and Wellbeing Review (2).

The notion of ‘wellbeing has particular appeal in harsh economic times suggesting an aesthetic of health, happiness and quality of life that surpasses the importance of cash income. For example, the Boorman review defined staff health and wellbeing in terms of ‘more than just the absence of disease’ and as ‘an emphasis on achieving physical, mental and social contentment’ (3). Not surprisingly, as ‘wellbeing’ has gathered appeal in a range of national policy arenas the merits of this ‘slippery concept’ have been debated. From a review of the definition, usage and function of the term in a range of British public policy arenas, Ereaut and Whiting (10) observe that:

‘Wellbeing has a ‘holographic’ quality; different meanings are being projected by different agents and what is apparently meant by the use of the term depends on where you stand. There are few fixed points of commonalities beyond ‘it’s a good thing’. Effectively wellbeing acts like a cultural mirage: it looks like a solid construct, but when we approach it fragments and disappears.’ (5).

Several writers caution against the use of a ‘catch-all’ term without precise meaning - for example, Veenhoven (11) - while others argue that the value of this hybrid term is that it allows for multi-disciplinary and multi-levelled discussion and analysis (12). Our interest is in wellbeing at work, and here a number of related concepts have come to be recognised as important to study, which we now examine.

Experiences at work whether physical, emotional, psychological, or social affect the worker while they are in the workplace, and can ‘spill over’ into

non-work. The workplace carries increased risk for some workers and health and wellbeing can have important consequences for workers: *'Researchers and managers have generally recognized that health and wellbeing can potentially affect both workers and organisations in negative ways'* (13). Dame Carol Black's 2008 review of health and wellbeing of the UK workforce suggested there was considerable evidence that health and wellbeing programmes produced economic benefits across all sectors and all sizes of business-that good health is good business (1).

There is an extensive literature on wellbeing at work from organisational psychology and the management literatures, with several seminal texts (13-15). It is beyond the scope of this study to review all this work, rather we will draw on this literature to identify the key aspects of wellbeing at work. We return to this literature later in more detail (Chapters 7 and 8) in relation to operationalising concepts for this study, particularly in our staff survey.

Warr (16) suggests work-related wellbeing can be defined as an 'individual's subjective experience and functioning at work'. In his seminal review (14) he distinguishes between job-specific wellbeing - people's feelings about themselves in their job - and more general feelings about one's life - namely context-free wellbeing. Warr suggests that job-specific and context-free wellbeing may be viewed in terms of three axes: displeasure-to-pleasure, anxiety-to-comfort and depression-to enthusiasm (17, 18). Whilst key job features such as physical security, valued social position and opportunity for skill use, will all impact on a worker's level of wellbeing at work, job-specific wellbeing is not only influenced by these key job-features.

Two main dimensions of wellbeing at work are commonly identified in the literature (19). These are firstly, individuals' subjective experiences at work including, for example, various aspects of job satisfaction, and both positive and negative work-related affect (14). Job satisfaction is a core indicator of employee positive wellbeing at work and is "a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences" (20). Positive and negative work related affect relates to positive or negative emotions and moods at work, such as cheerful optimistic, enthusiastic, cheerful or feeling worried, depressed, uneasy and tense (21-23). Secondly psychological and physiological aspects of employee health at work include, for example, job-related stress, anxiety, burnout and exhaustion (22). Emotional exhaustion has increasingly come to be regarded as the core dimension of burnout (23, 24) and refers to the feeling of being overextended and depleted of one's emotional and physical resources (25).

Other related concepts in terms of wellbeing are those aspects considered to be antecedents and consequences of work related wellbeing. There is an extensive theoretical and empirical literature dealing with the antecedents of work-related wellbeing (22, 26, 27). Antecedents include for example key job demands and resources linked to core employee experiences at work. An important stream of thinking in the OB and OP literature focuses

specifically on the impact that employee experiences at work have on various aspects of their wellbeing from the perspective of job demands and resources. Work experiences, or perceived working conditions, can directly contribute to the satisfaction of important individual needs at work, such as autonomy, support, and belonging. Both positive and negative aspects of wellbeing are directly related to key work experiences including, for example, perceived job demands, job control, social support, role ambiguity, role conflict and distributive justice (28-31). In the job demands-resources (JD-R) model, these key job attributes and work experiences can be grouped into two broad categories of work-related demands and resources (32). Job resources include factors such as job autonomy, supervisor and co-worker support, and access to information, while job demands include both so-called hindrance demands (e.g. role ambiguity, role overload, role conflict) and challenge demands (e.g. job complexity and job responsibility) (33). Job resources have been shown to be positively related to positive psychological states, such as work engagement, and negatively related to negative aspects of wellbeing, such as burnout. Job demands, on the other hand, and in particular hindrance demands, have been shown to be positively related to burnout, but negatively related to positive psychological states such as engagement (33). Hobfoll's conservation of resources (COR) model (34-36) also provides a useful means for analysing the effects of work experiences on wellbeing. Hobfoll (34) defines resources as those conditions that "either are centrally valued in their own right, or act as means to obtain centrally valued ends" (e.g. job control, social support).

Also recognised as important antecedents of work related wellbeing are various characteristics of individuals (individual difference factors), and various aspects of the past in-role and discretionary performance of employees (past performance factors). Drawing on the Job Demands and Resources (JD-R) model (32, 33) and the conservation of resources (COR) model (34-36) personal resources, in the form of individual work orientations and job skills, can also be seen as potential antecedents of employee wellbeing. For example, consistent with psychological capital arguments and research (37-39), an affective patient orientation, work dedication and high levels of job competence and skills can be seen as personal resources that can contribute to individual wellbeing by enabling employees to cope and adapt more effectively to difficult or stressful work situations.

In summary, our approach to wellbeing in this study is to take a broad definition that starts with Warr's definition: 'individual's subjective experience and functioning at work' (16) and includes aspects of wellbeing such as job satisfaction, affect and motivation (including positive and negative affective reactions at work), emotional labour and issues of emotional exhaustion and burnout. Henceforth we use the term 'wellbeing' to denote and include all of these issues. Our definition also recognises the importance of antecedents of employee wellbeing such as personal resources e.g. individual work orientations and job skills; job resources such as job autonomy, supervisor and co-worker support, and access to

information, and job demands - hindrance demands (e.g. role ambiguity, role overload, role conflict) and challenge demands (e.g. job complexity and job responsibility).

2.2.2 Staff wellbeing in the healthcare sector

It is known that the majority of healthcare staff are, at least initially, motivated by ideals of altruism and making a difference to people's lives (40) (41). Some ways in which motivation is affected have been identified (40, 42). Constructs, that are of importance in the wellbeing at work literature outside health and which might be expected to be of importance in a healthcare setting include, employees' level of job satisfaction (14, 20, 43), stress and burnout at work (13, 22-25), level of professional identification and involvement in the job (44) (45), levels of emotional labour and systems of support to alleviate these (46, 47) (48). Key work experiences may include job related factors such as employees' perceived level of job demands and control, of role conflict and ambiguity and their perceptions of the climate for patient care in the workplace (49) (50) (42) (51-54).

Here we examine why wellbeing at work is of interest and is a 'problem' for health care. Firstly, we examine current state of wellbeing in the healthcare workforce, with particular reference to stress and burnout, and briefly examine some of the known causes, or antecedents, and the consequences of the high stress and burnout experienced by NHS health care staff and ways of intervening to alleviate these. Subsequently in our section on patient experience, below, we briefly examine the how staff wellbeing may be a problem in terms of patient experience – how it impacts on those on the receiving end – in the final section we examine studies and evidence of the links between staff wellbeing and patient experience. First then, the current state of wellbeing in the healthcare workforce, with particular reference to stress and burnout.

Wellbeing in the healthcare workforce

There has long been concern with the demands placed on staff in healthcare and the affects of these on the health and wellbeing of staff (30, 55). Medical and nursing staff are known to have high levels of stress (56, 57), burnout (58, 59) and psychological morbidity (60, 61).

Levels of ill health, both physical and psychological, and associated sickness absence are higher amongst those working in health care than in the rest of the UK working population (62, 63). Explanations for this include the nature of the work, organisational change, the large amount of work, and the pressure of the work (55). One way in which ill health manifests in healthcare staff is through high levels of stress and burnout.

Psychological studies of stress and burnout

Concerns with health professionals wellbeing through the 1980s and early 1990s crystallised around psychological studies of stress, 'burnout' and mild psychological morbidity (56, 59, 64). Burnout, as a form of work-related strain, is the result of a significant accumulation of work-related stress

(65). Maslach (58) defined burnout as 'a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind' (p3). Research on stress and burnout in nursing and medicine has consistently identified high levels of both in clinical staff (57, 66). In terms of healthcare staff, much of the research on stress and burnout for example has focused on uni-professional groups, often doctors and nurses, with work undertaken in professional silos with support staff largely excluded. Effects upon patient care are however evident in this literature. For example, doctors with high levels of stress and burnout report irritability with patients and colleagues (66, 67) or lowered standards of care due to tiredness and pressure of overwork (67). Doctors' reports of irritability with patients may be linked to the work context and staff coping with increasing demands and work stress through taking 'short cuts' (60, 67, 68).

In the UK, we now know much more about the experiences of NHS staff with the development of the national staff survey. Since 2003 the NHS staff survey has been one way that aspects of staff wellbeing have been measured in the NHS (See Appendix 2 for more details). These surveys help us understand trends in levels of stress, bullying, and staff engagement. For example in 2010 29% of NHS staff reported work related stress (down from 39% in 2003) and 15% assaults, harassment, bullying and abuse from patients (27% ambulance crews), down from 28% overall in 2003.

A comparison across UK hospital trusts found that rates of psychological ill health varied from 17% to 33%, with lower rates in hospitals characterised by smaller size, greater cooperation, better communication, more performance monitoring, a stronger emphasis on training and allowing staff to have more control and flexibility in their work (61). High occupational demands, workload and long hours are cited as contributors to stress related illnesses in doctors, nurses, dentists, and occupational therapists (4). For example, occupational therapists and nurses report staff shortages as being one of their most significant stressors (69-71), found that overwork was the primary cause of stress and depression in female junior house officers and a more recent study in Finland found a correlation between overcrowded wards in general hospital (bed occupancy 10% higher than limit for six months) and the use of anti-depressants by doctors and nurses (72); higher patient workload has also been found to predict compassion fatigue in genetic counsellors (73). A study of healthcare staff in Sweden (74) suggested factors such as emotional exhaustion were to do with feelings of troubled conscience, and staff reported 'having to deaden one's conscience', and 'stress of conscience' from lacking the time to provide the care needed, work being so demanding influenced home life, and not being able to live up to others' expectations (75). Thus leading determinants of staff stress and burnout were identified as the organisational structures and processes surrounding patient care work and NHS staff were identified as more vulnerable to stress-related behaviours and illnesses than staff in other organisations (61).

Some work has been undertaken in healthcare to examine some of the causes or antecedents of the high stress and burnout experienced by health care staff. For example, the Boorman review (2, 3) suggests certain management practices can contribute to stress and mental health problems among staff, including reported high levels of bullying and harassment, a deep-seated culture of long working hours and an apparent lack of managerial interest in, and support for, staff concerns about their health and wellbeing, which is supported in the wider literature (71, 76, 77). Indeed poor work communication is associated with work related stress (76) and role ambiguity: as shown for Accident & Emergency consultants (78), nurses (79) and dental assistants (78). Conversely, staff who feel able to talk to their managers about their health, those who feel valued and those who are satisfied with their responsibilities report lower levels of stress than those who feel unable to talk to their managers, do not feel valued or are dissatisfied with their responsibilities (2) [p34], supporting wider literature suggesting high levels of social support at work can have a protective effect on healthcare professionals mental health (80-82). Finally in terms of trying to manage the antecedents of stress and burnout, the Boorman review also suggests attention to job design or organisation in many healthcare organisations, requiring more attention be paid to developing jobs into 'good jobs' with meaningful work that help staff to feel valued (3) [p12].

In terms of managing the consequences of stress and burnout in healthcare staff, the NHS has developed a number of strategies. Accessible Occupational Health Services, including a mental health component, alongside workplace support such as mentoring, clinical supervision and responsive line management are seen as important for dealing with the consequences of stress and burnout. These strategies are clearly important for the benefit of individual staff as well as the organisation as a whole (83).

Finally drawing on the organisational management literature on 'work cultures' the NHS has also sought to change 'basic values, beliefs, and assumptions that underpin patterns of behaviour in the delivery of care', typically through organisational investments in life-long learning and clinical governance (84) [p1408]. However, health professionals express more loyalty to their work and their patients than their organisation, making it important for organisational and professional- or patient care-values be attuned (85). In the US research into workplace empowerment amongst nurses echoed this position, noting that when 'managers create organisational structures that empower nurses to deliver optimal care; they promote a greater sense of fit between nurses' expectations of work life quality and organisational processes and goals' (86) [p364]. In contrast, the Department of Health commissioned study of 'What matters to staff in the NHS' (5) documented the felt disjuncture between the values expressed by staff, which centred on vocational and emotive drivers of care, and the values that staff sensed in their employing organisations, which centred on the rationale of productivity and organisational efficiency.

In summary, some healthcare workers report poor psychological wellbeing, and suffer from work-related stress; often resulting from high expectations coupled with insufficient time, skills and/or social support at work. This can lead to distress, and burnout which can result in increased absenteeism and staff turnover.

2.3 Patient experience

Some aspects of patient care in the UK's NHS are to be celebrated – gone are the long waiting lists and patients are treated quicker, and there have been great advances in the treatment of many diseases, such as cancer, where patients are living longer and with an improved quality of life. However, in recent years there has been much disquiet about another aspect of health care – the patient experience – ‘the most important characteristic of any health system is how patients are ... cared for, how they are looked after’ (87). A series of damning reports including public enquiries, Ombudsmen and Patients Association reports cite evidence of patients receiving inadequate food and water, poor hygiene care and of rough, rude and inconsiderate care delivery.

The way that people are treated as an individual, as a person is seen as a hallmark of quality – much vaunted in consumer industries outside of health and now patient's coherence in the NHS has itself become a national priority. Healthcare professionals and patients have long known that caring for patients well is not only the right thing to do, it also aids recovery and makes business sense (88-91). Today's patient is almost invariably vulnerable, very sick and in need of support and care at a time of anxiety, discomfort or distress. Whilst staff do not go to work to give ‘bad care’, from the patient perspective sometimes that is what happens, with how staff communicate with them one of the issues raised most by patients. ‘Currently, there is evidence to suggest that we should be worried about this most fundamental interaction between health care staff and their patients’ (87).

Patients' experiences have therefore become increasingly central to assessing the performance of healthcare systems worldwide. It is now common to judge quality of care not only by measuring clinical quality and safety but also by gathering the views of patients in receipt of care (92). We use the term 'patient' henceforth to include service users (and, where appropriate, relatives and carers as proxies for patients).

2.3.1 A framework for understanding patient experience

The most widely known set of existing domains is arguably the Institute of Medicine's (IoM) six core dimensions of patient-centred health care (93):

- compassion, empathy and responsiveness to needs, values and expressed preferences
- coordination and integration
- information, communication and education
- physical comfort

- emotional support, relieving fear and anxiety
- involvement of family and friends.

The Department of Health's own research - to inform the development of the NHS Constitution - found that there are four areas that really matter to patients:

- get the basics right;
- fit in with my life;
- treat me as a person; and
- work with me as a partner in my health (5).

Perhaps more pertinent to the NHS is the Picker framework which was the basis for the original national patient surveys in acute hospitals in England. Its formulation is basically the same as the IoM, although the language is slightly different. In addition to the IoM dimensions above the Picker framework includes 'access' as one of the eight dimensions and it explicitly identifies 'continuity of care' as a separate dimension (the Institute of Medicine includes this aspect within a broader dimension of 'coordination and integration of care'). Both of the possible frameworks are based on the same original research by Gerteis et al in the USA, cited in Cleary et al (94, 95), which is technically sound, useful and widely recognised.

In 2007, examining patient-centred care on behalf of the Picker Institute, Shaller argued that national and international studies suggest that although patients rated their care highly they still reported 'significant problems in gaining access to critical information, understanding treatment options, getting explanations regarding medications and receiving responsive, compassionate service from their caregivers' (96) [p1]. However, Shaller argues there is consensus regarding the key attributes of patient-centred care from a review of nine models and frameworks for defining patient centered care, and six core elements were identified most frequently:

- education and shared knowledge
- involvement of family and friends
- collaboration and team management
- sensitivity to non-medical and spiritual dimensions of care
- respect for patient needs and preferences
- free flow and accessibility of information.

We return to these frameworks below and when developing tools for this study, see below.

2.3.2 'Relational and 'transactional' aspects of care

A recent King's Fund report (97) highlighted that providing a good patient experience is multi-dimensional: it is about both the what (functions or transactions) and the how (relational) of interactions with patients. A functional aspect of care is defined as 'care that meets the preferences of the patient as far as timings and locations of appointments are concerned... that meets needs diagnosed with accuracy for an individual using genetic and other data.' A relational aspect of care is defined as 'care that forms part of an ongoing relationship with the patient and perhaps the family...in

which someone gives a hoot about what experience is and the outcomes are' (p14 (98)).

Iles (99) describes the 'transactional' aspect of care as a set of 'efficient auditable transactions between consumers and providers.' She also speaks about the 'covenantal' aspect of care; 'a covenant between care giver and care receiver...that recognises that neither is an impersonal unit in a care transaction... but a whole richly multifaceted person whose physical responses are strongly bound to emotional ones.' (p36). She highlights the dangers of not taking into account both aspects of care: the 'content of care' as well as the 'nature of care' which is equally important for patient experience.

Emerging findings from related research undertaken by authors of this report support the critical importance of 'relational' aspects of care alongside 'functional' aspects in terms of what matters most to patients (100). Analysis also revealed that it is the relational aspects of care that mattered most to patients. For example, themes such as 'being treated as a person, not a number' and staff 'who listen and spend time with patients' were considered the most important aspects of care among patients.

Figure 2 below illustrates what Cornwell calls the 'nature of the challenge'; how delivering truly patient-centred care (based on the IoM framework but could equally be applied to the Picker dimensions) is dependent upon addressing both the functional and the relational aspects of patient experience.

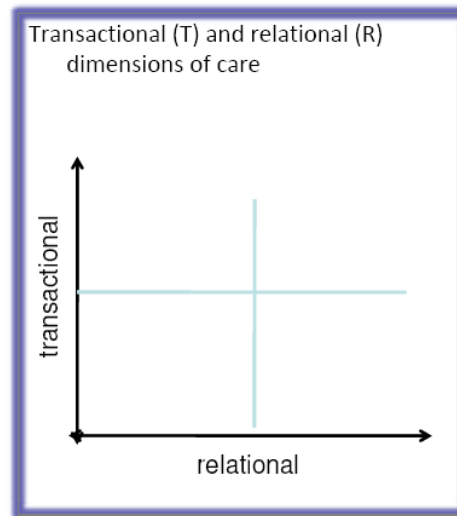
Figure 2. Relational and transactional aspects of care as applied to Institute of Medicine framework

The nature of the challenge

Patient centred care

- > Compassion, empathy and responsiveness (R)
- > Co-ordination and integration (T)
- > Information, communication and education (T & R)
- > Physical comfort (T&R)
- > Emotional support, relieving fear and anxiety (R)
- > Involvement of family and friends (T&R)

Source: Institute of Medicine, *Crossing the Quality Chasm*, 2001



Adapted from the IoM by J Cornwell

Shaller's (96) research with opinion leaders selected for their experience and expertise in either designing or implementing strategies for achieving excellence in patient-centred care plus a review of the literature identified seven key factors that contribute to achieving patient-centred care at the organisational level. These were:

1. **Leadership**, at the board level, sufficiently committed and engaged to unify and sustain the organisation in a common mission.
2. **A strategic vision clearly and constantly communicated** to every member of the organisation.
3. **Involvement of patients and families** at multiple levels, not only in the care process but as full participants in key committees throughout the organisation.
4. **Systematic measurement and feedback** to continuously monitor the impact of specific interventions and change strategies.
5. **Quality of the built environment** that provides a supportive and nurturing physical space and design for patients, families and employees alike.
6. **Supportive technology** that engages patients and families directly in the process of care by facilitating information access and communication with their caregivers.
7. **Care for the caregivers through a supportive work environment** that engages employees in all aspects of process design and treats them with the same dignity and respect that they are expected to show patients and families (96).

In summary, the patient journey and experience, and how patients are cared for and looked after, are centrally important in any assessment of quality and performance of healthcare throughout the world. A number of patient-centred health care models have been developed which set out core components of the patient experience including those developed by the Institute of Medicine (IoM) and Shaller in the USA and Picker in the UK. Providing a good patient experience is multi-dimensional; transactional (the what) and relational (the how) of interactions with patients. The latter is dependent on staff members taking care to make sure the patient has a good experience.

2.4 The link between patient experience and staff wellbeing

Until recently the intuitive view of the relationships between staff wellbeing and patient experiences of care has been that 'happy patients produce happier staff and vice versa' (101-103). More recently studies suggest a much greater complexity. Studies indicate that, from both organisational and an interpersonal care perspective, the quality of staff wellbeing is shaped at least as much by the quality of immediate working relationships (104-106) and by workplace behaviours of staff towards each other (107). The felt disjuncture between patients' expectations and experiences of care are often mediated by patients' sympathies with staff working in the 'difficult circumstances' of the health service (108).

In Sections 2.4.1 to 2.4.3 below we summarise the theoretical and empirical basis for links between patient experience and staff wellbeing. We first examine theories from outside healthcare, before examining empirical work in the UK NHS on the link between patient experience and staff wellbeing, before finally examining empirical studies from other healthcare contexts.

2.4.1 Theories from outside healthcare literature

We have already presented a number of theories and literature on the antecedents and consequences of both wellbeing and patient experience, we now examine theories of emotions at work, emotional labour and customer orientated care and how these may be applied to understand any link between staff wellbeing and patient experience. There are a number of theories from the management and OB literatures, and here we present two, which have received some attention in health: emotional labour has been widely applied (109-111), whilst emotional contagion (112, 113) is less well known.

Emotional labour

In the complex world of healthcare, research on emotions provides insights into the negotiation of values and relationships within organisations; highlights the centrality of emotional work to the experience of patients; and draws attention to the skills and support that staff may need to deliver emotional work. Since the 1990s the emotional dimensions of healthcare work and patient emotions have both become substantial areas of research.

Such research emphasises the significance of patient's emotional needs as part of their experiences of care (114).

In general terms, patients want staff to communicate with them effectively, to show compassion and patience, show that they care about them and that staff connect with them as an individual person (87, 100, 115). To meet these expectations staff may need to actively manage their emotions in the workplace in order to support patients and create a positive emotional state in them. Staff must also get along with work colleagues – which can also involve managing their emotions despite what they might actually be feeling.

The active management of emotions was first described by the sociologist Arlie Hochschild, who used the term 'emotional labour' to describe management of feeling to create a publicly facial and bodily display (116). In her seminal work *The Managed Heart*, Hochschild (117) describes the expression of emotion and creation of feelings that were an expected part of flight attendants' work roles. She defined other jobs involving emotional labour as those that:

- require face-to-face or voice-to-voice contact with the public
- require the worker to produce an emotional state in another person and
- 'allow the employer to exercise a degree of control over the emotional activities of employees'.

Employers may wish to control, or encourage, the emotional responses of staff because it is good for business. Positive emotions can generate positive responses in consumers, through 'emotional contagion' (112, 113) and this concept is discussed in more depth in the following section. Yet employers have not generally recognised the demands of 'sentimental work' (118-120) or provided compensating wage differentials for jobs involving emotional labour (121, 122). Consumer research shows display of positive emotions in service interactions, such as smiling and conveying friendliness, is positively associated with perceived service quality, intention to return and to recommend a store to others (123). Thus employing organisations often have expectations or 'display rules' about what kind of emotions staff should express on the job (124). In the context of healthcare, display of positive emotions is an aspect of clinical empathy and caring (125, 126) as well as service excellence (127).

Employees may modify their emotions and expressions to align with organisationally-desired emotions – a process called 'emotion regulation' (124, 128). Emotion regulation can take two forms: deep acting, whereby staff modify their inner feeling to feel genuine empathy with the patient or the organisation; and surface acting, which is more akin to 'faking' emotions or putting on a 'façade' (117). Conceptual links have been made between emotion regulation and staff wellbeing (129). Deep acting is thought to be associated with reduced stress and an increased sense of personal accomplishment (130, 131). Surface acting is thought to lead to a

sense of inauthenticity, increased stress, emotional exhaustion and lower job satisfaction (124, 132-134).

Studies of the emotional underlay of organisational life (see for example (135-137)) show that the wider context, such as the rationale and science of healthcare delivery, affect individuals and the organisations in which they work. Behavioural theories have further informed understandings of the negotiation of emotional work, including motivational theory, the psychological contract, and organisational citizenship (138-140). A further line of theory development has sought to relate affective and emotional responses to workplace events in order to understand the relationship between emotion in an organisation and the affects on staff working there (139-145).

Healthcare research has made use of the concept of emotional labour to examine the nature and affects of emotional work (146, 147) and to raise questions about the ethics and professionalism of emotional work (148, 149). Appendix 4 summarizes 22 empirical studies of emotional labour in healthcare returned by our literature searches (detailed in Appendix 3) and a review of references of seminal sources. Early interest in emotional labour in nursing helped to draw attention to the added value, or burden, of emotional aspects of carework (150-155). There is strong evidence that staff and patient aspirations for care, and the relationships that may ensue, are mediated by employing organisations, professional cultures and differences in the nature of carework in different settings (109, 110, 156).

Research shows that nurses draw on their personal knowledge and moral perspectives to inform emotional encounters with patients and to manage emotional demands placed on them (157). However, nurses may experience uncertainties and tension between 'nurse altruism' (being empathetic towards patients – or authentic caring behaviours), 'professional feeling rules of detachment' (158), and 'market mentality' (being consumer-focused – or 'forced niceness') (159). It can be difficult for staff to find balance in their work; and professional demeanour and peer support are recognised as being important for nurse wellbeing (156). Other research shows that small talk and humour amongst colleagues can promote teamwork and collaboration (105).

There is some evidence that display rules are associated with individual nurse job satisfaction (160). A meta-analysis of 95 studies (161) showed surface acting is associated with impaired wellbeing and job attitudes; and a small negative relationship with performance outcomes was also detected. Deep acting displayed weak relationships with impaired wellbeing and job attitudes, but positive relationships with emotional performance and customer satisfaction. These findings are supported by international research: from Japan which shows suppressed expression, deep adjustment, and surface adjustment of emotional labour are occupational stressors for nurses (162); research from Taiwan which shows emotional display and deep acting are positively related to job satisfaction (163); and research on stress and emotional wellbeing of community palliative care nurses in Australia (164).

Concepts of work-group emotional climate (165) and collective emotional labour (166) have informed research to understand the emotional qualities of staff interrelationships. For example Fulton (167) used observational techniques to show differences in nurse-patient interactions in different care settings (surgery and haematology) of a hospital. These differences are explained as organisational systems of units where nurses learn to develop the skills to deal with patient's emotional needs. However, other factors come into play, such as how individuals perceive unit-level display rules and the emotional regulation strategies they may choose to adopt (160). Nurse's perspectives of emotional labour are also informed by traditional and modern images of nursing, gender and professional relations in health work (146).

A theme of the research literature is how nurses learn about emotional labour; such as through nurse training, role models or mentoring (168, 169), and reflective practice (170). Emotional labour has become a more explicit element of healthcare professional education. Students may learn techniques for managing patient consultations and gain an appreciation of the potential therapeutic value of emotional labour (171). However it is not only student nurses that learn skills in emotional work, established nurses also learn to manage their emotional responses. For example community nurse leaders use surface acting to mask their emotions and to maintain a dignified and professional demeanour with colleagues, which can be supported by coaching or mentorship (172). These trends indicate that healthcare staff need support to understand the emotional complexities of the organisations they work within (173) and skills training in coping strategies to reduce job-related stress (174).

Collectively these literatures on emotional labour convey three key developments in understanding, which have informed our fieldwork and helped shape our findings. These developments are:

1. A movement in focus from individual staff behaviours within work settings towards a more dynamic view of organisational contexts which produce values and relationships and allow for their negotiation.
2. A shift in perceiving emotional work or labour as fundamentally harmful (a product of the commercialisation of emotion) to fundamentally vital, and a sometimes positive aspect of the work of health professionals and the experiences of patients.
3. Growing recognition of the importance of staff skills and techniques in emotion management and making emotional aspects of care more explicit in the education, training and support of healthcare staff.

Emotional contagion

Theories of emotional contagion and 'feel good-do good' also contribute to our understanding of the effects of expressed emotion on other people and the links between staff and patient experience. Emotional contagion is a process in which a person or group influences the emotions or behaviour of

another person or group by their expressed emotion. The human tendency for mimicry explains why people can transfer their good and bad moods to each other. Indeed, (primitive) emotional contagion has been defined as an automatic human tendency to converge emotionally through mimicking and synchronizing facial expressions, vocalizations and postures with those of another person (175). Research suggests that changing facial expressions alters people's emotional experience (176); so it stands to reason that mimicking others can facilitate emotion transfer.

Because mimicry often occurs automatically (177), emotional contagion may occur unconsciously, and people might not know how it is influencing them (178, 179). However, contagion may also occur consciously, for instance when individuals imagine themselves in the position of another (180).

Empirical evidence of the importance of emotional contagion in applied settings is mounting. In the business world, contagion can lead customers to 'catch' the displayed emotions of employees, and this may influence their evaluations of service quality (178).

In healthcare, several studies have examined how emotions spread between healthcare professionals. One study found a relationship between the mood of individual nurses and that of the rest of their team, even when negative events (which might affect the whole team) were controlled for (181). Two further studies focused on the transfer of burnout between healthcare professionals (182, 183). The first study focused on burnout among general practitioners (GPs), and reported that burnout among colleagues and susceptibility to emotional contagion were both associated with emotional exhaustion, which in turn was linked with negative attitudes towards patients (182). Burnout was said to be like an infection which can spread from clients to staff, from staff to (other) staff, and from staff back to clients. In the second study, a survey of more than 1800 nurses working in 80 Intensive Care Units across Europe found that nurses can 'catch' feelings of burnout through non conscious emotional contagion, by 'tuning in' to the emotions of others. 'Burnout complaints'; nurses noting how many of their colleagues were burnt out, were the strongest predictor of burnout at individual and unit levels, even after common stressors were controlled for (183).

Omdahl (112) examined the transfer of emotions (specifically burnout) between patients and nurses. Emotional contagion (sharing / adopting of patients' emotions) was positively associated with burnout, while empathic concern (concern for patients' wellbeing without emotion sharing) was negatively linked to it. These studies suggest that when clinicians imagine themselves 'in the shoes of others' rather than when they show a more general empathic concern, emotion transfer may occur between clinicians and patients.

In summary, research suggests that emotional contagion is a significant social phenomenon which occurs in a variety of applied settings, including healthcare. Emotional contagion helps to explain why it matters for patients

how their doctors and nurses express their feelings, how happy, sad, angry or upset they feel and the state of their psychological and physical wellbeing.

We now turn our attention to examining the link between patient experience and staff wellbeing in empirical studies, firstly in the NHS and subsequently outside the UK system.

2.4.2 Reviewing the link between patient experience and staff wellbeing

Despite early work by Revans (184) exploring the association between staff morale and patient length of stay in hospitals, the precise nature of the relationship between staff and patients' experience is only beginning to be understood by researchers.

We undertook a scoping review with the aim of reviewing empirical studies in the NHS and other countries that have explicitly sought to explore the link between staff wellbeing and patient experience. Appendix 3 details the search strategy, inclusion and exclusion criteria and how we tabulated and analysed the data. The following paragraphs provide an overview of the results tables presented in Appendices 6 and 7.

Appendix 5 summarises 9 empirical studies included in our scoping review that have sought to directly study the link between staff wellbeing and patient experience in the NHS context. Many of these studies are based on cross-sectional surveys or secondary analysis of existing survey programmes. For example, Raleigh et al (185) found associations between positive staff feedback and positive patient feedback in the annual NHS patient and staff surveys which might be generalized to associations between staff and patient experiences. In other words, where staff have good experiences, so too, it seems, do patients.

Firth-Cozens' (67, 186) surveys - and Taylor's later study (60) - focused exclusively on wellbeing in doctors and only indirectly link this to patient experiences; Michie et al's small-scale survey of nurses (187) was similar in focusing on only one professional group but did include direct measurement of patient satisfaction. Two studies by West et al (188, 189) explored the link between HRM practices and patient mortality. Robertson et al's (190) study of nursing staff was set in psychogeriatric units in NHS hospitals in Scotland and combined a survey instrument and an in-depth observational study where quality of care was studied through standardized recording of staff's feeding, toileting and bathing of a stratified sample of patients. The findings pointed to a very strong relationship between job satisfaction and quality of patient care. The authors suggested that this relationship was mainly attributable to management practices, particularly at ward level, which influence both job satisfaction and quality of patient care. Michie and West's work that underpinned the original development of the NHS staff survey included a review of studies that explore, for example, the links between emotional exhaustion and supervisor rated job performance (191), job satisfaction and job performance (26) and job satisfaction and absenteeism (192). Overall, however, the empirical evidence base of direct

links between staff and patient experiences in the NHS remains relatively weak - causality has not been demonstrated - and significant methodological challenges remain.

We identified 39 empirical studies directly studying the link between staff wellbeing and patient experience in the non-NHS context (see Appendix 6). These studies have used a range of concepts to examine aspects of staff wellbeing (job satisfaction, staff commitment, staffing levels, organisational climate/work environment, emotional exhaustion, stress, burnout) and patient experience (patient outcomes, patient safety, patient satisfaction). Research approaches range from large-scale multi-national surveys to in-depth qualitative and observational studies of healthcare teams. As a whole, the literature suggests that promoting patient experience, enhancing staff working conditions, and improving the satisfaction and commitment of employees are not necessarily separate activities in competition for resources or leadership (193). Indeed, identifying and preventing circumstances of staff burnout and dissatisfaction can enhance staff engagement and patient experiences of care (191, 194-196).

Several studies show that healthcare staff are more likely to feel dissatisfaction with their work when they experience low staffing levels, time/workload pressures and lack of support (194, 197-199). Negative staff feelings (frustration, tension, lack of time) correlate with giving little explanation to patients about their condition or care (200). Staff burnout is associated with reduced patient safety (201, 202), longer post discharge recovery time (203) and staff are less likely to report mistakes if they suffer burnout (203). Staff who are emotionally exhausted are more likely to feel they are not performing to their potential and disengage from the organisation (138, 204).

There is also evidence to show staff dissatisfaction contributes to negative patient outcomes (205). In particular, large-scale studies of American hospitals with high patient-to-nurse ratios show surgical patients have higher rates of mortality and nurses are more likely to experience burnout and job dissatisfaction (102). Research from Taiwan demonstrates that time pressure among nurses reduces patient-perceived reliability, accountability, responsiveness and assurance (206); and the situation is made worse when staff feel they are burnt out (207). Furthermore a strong relationship exists between team stress levels and the occurrence of negative patient incidents (208, 209). Patient's perceptions of nurse staffing is strongly associated with patient's perceptions of nursing care received (210).

Fewer studies show that staff who experience positive feelings towards their work provide better quality of care to patients (202, 211). Research with 57 general practitioners in The Netherlands (200) shows that many positive feelings (satisfaction, feeling at ease) correlate with more openness to patients, more responsiveness to psychosocial aspects of care, and a higher referral rate to medical specialists. Higher levels of professional commitment in nurses in Taiwan positively influenced patient experiences of care in terms of patient perceived responsiveness and empathy (201).

Similarly, research on 255 Certified Nursing Assistants (CNA) in the US found that greater job commitment of CNAs is associated with better quality of relationships and life for residents (212). In Canada, patients in hospital units where nurses found their work meaningful were more satisfied with all aspects of their hospital stay, including care provided by doctors, information provided and coordination of care, and outcomes of the hospital stay (213).

Social and environmental attributes of organisations are also known to affect staff and patient outcomes. Significant correlations have been found between hospital nurses' perceptions of organisational support (214, 215), nurses' satisfaction with their jobs (216), and nurse turnover (217). A related factor is person-environment fit, including congruence between caring orientation (high/low) and patient-centred care behaviours (218). Staff perceptions of their work environment have been linked to patient perceptions of the quality of care, for example violence experienced by healthcare staff in Sweden was associated with lower patient ratings of the quality of care (219). Although organisational factors influence patient satisfaction, more significant factors can be older age, health status and symptom management. Patient satisfaction also varies by geographical region, as does healthcare professional's satisfaction with their career (220).

Staff support and mechanisms that foster engagement are associated with higher patient satisfaction (221). Support and motivation from nurse managers clearly enhances the job satisfaction of their staff (190, 222-224). Nursing leadership, in particular transformation leadership style and lower span of control (225), also plays a fundamental role in nurses' quality of work life (198) and lower staff turnover (226). Strategies that may promote staff empowerment include improving methods of communication throughout the organisation, for example during the orientation process providing information about opportunities, support, and resources available to healthcare staff can enhance their productivity, effectiveness, and job satisfaction (224, 227). Interventions for job related health promotion can also improve staff working conditions and staff perceptions of their ability to provide quality care (209).

2.4.3 Organisational interventions to improve staff wellbeing in the NHS context

Research outside health suggests, for example, that human and resource management (HRM) practices adopted by organisations can have a significant impact on the way front-line workers behave towards customers (50, 228-232). In particular, different combinations of HRM practices have been found to affect both motivation and the capacity of front-line staff to engage in forms of work behaviour that are explicitly designed to benefit customers (44, 49, 53, 233-235). This type of customer-oriented behaviour has been shown to have a direct positive impact on customer satisfaction at an individual and aggregate level of analysis (51, 236, 237).

Our searches identified one systematic review and four empirical studies (see Appendix 7) which have specifically examined what NHS organisations can do to improve staff wellbeing, with the assumption that improvements in policy and practice will lead to better quality patient care.

A cross-sectional study of five large companies (production, financial services, retail, and one hospital trust) examined HR policy implementation from the perspective of different employee groups (238). The study used employee surveys (609 face-to-face interviews with 428 employees) and analysis of the impact of HR management on organisational performance measures (staff turnover, retention, absence, accidents, employee satisfaction measures, and business related operational measures). Staff reported factors affecting performance were teamwork, involvement, culture and leadership. Managerial behaviour (leadership style and ability to bring policies to life) accounted for performance variations in organisations; for employees' satisfaction with managerial behaviour and for their overall organisational commitment. Across all five companies three types of employees (professional, front-line managerial, workers) were identified as requiring a different policy mix to support their organisational commitment. In particular nurses, in contrast to other hospital staff, were identified as having specific HR requirements to support good work communications (good leadership), recognition and good rewards.

A systematic review of HRM theory and empirical literature on the link between HRM and staff performance aimed to inform improvements in patient care in the NHS (239). Secondary analysis of 97 research studies (multiple sectors and international) revealed strong associations between HRM and performance, but there was little evidence that HRM causes changes in performance, or indeed improves patient experiences of care. The three HRM elements that demonstrated the largest number of positive associations with performance were: training/development; pay incentives; and involvement/voice.

Building on the review findings the Manchester Business School undertook six in-depth case studies in high performing NHS hospitals (n=170 interviews and staff questionnaire data) (240). The study found that although organisational strategies for HRM varied greatly, where staff expectations were met this led to more effective patient care. However, some individual staff experienced tensions between meeting organisational performance targets and their desire to provide care for patients.

Qualitative research with senior medical professionals and HR managers (n=6) working in the NHS (111) examined the role of various management functions and strategic potential of HRM. Interview data illustrates the changing roles of HR in NHS hospitals and the need to mediate between different values and professional and organisational interests by creating vocabularies that carry shared meanings and values for different groups in the hospital. From the perspective of HR managers' staff wellbeing was generally seen as an issue of improving occupational health and staff retention.

Goodrich & Cornwell (87) argue that improvements in NHS care cannot simply be achieved by individual staff acts and commitment; these must be backed by institutional, regional and national interventions. Their argument is underpinned by extensive qualitative research and policy analysis involving four NHS hospitals, to examine staff and patient's perceptions and experiences of care and care giving at the 'Point of Care'. Organisational factors identified as shaping patient experiences at the individual level include: education/training/qualifications, induction/preparation, job description, accountability, delegated responsibilities, permanent/temporary status, support, and supervision/appraisal. Other 'human factors' are also identified, including: staff morale, experience, health status, tiredness/stress, wellbeing, professional and personal attitudes/values, support, and spoken English. The findings suggest that quality of staff relationships with patients positively influences job satisfaction. However on the down side, the scale of health care undermines staff/patient relations by depersonalising interactions and reducing direct contact time with patients.

Many organisations are trying to create a balance between maximising productivity and the risk that their employees may burn out, make costly errors or resign. An understanding of a holistic approach that underlies wellbeing, and development of initiatives co-ordinated with other HR policies can offer an approach to achieve that balance. (CIPD 2007- What's happening with wellbeing at work?) (241)

As part of the NHS response to the recommendations in the Boorman review, the Department of Health's Wellbeing Delivery Group has developed a set of five high-impact actions that it believes will make the greatest difference to embedding staff health and wellbeing within NHS organisations. The high-impact actions are:

1. Ensure health and wellbeing initiatives are backed with strong leadership and visible support at board level. Producing an annual report of the organisation's wellbeing will help to communicate commitment and progress.
2. Develop and implement an evidence-based staff health and wellbeing improvement plan to meet organisation's needs. This should be prepared and agreed in partnership between management, staff and unions with progress monitored regularly.
3. Build the capacity and capability of management at all levels to improve the health and wellbeing of their staff. This will include recognising and managing presenteeism, conducting return to work interviews and supporting staff with chronic conditions.
4. Engage staff at all levels with improving their own health through education, encouragement and support.
5. Use an NHS occupational health service that offers a targeted, proactive and accredited support system for staff and organisations.

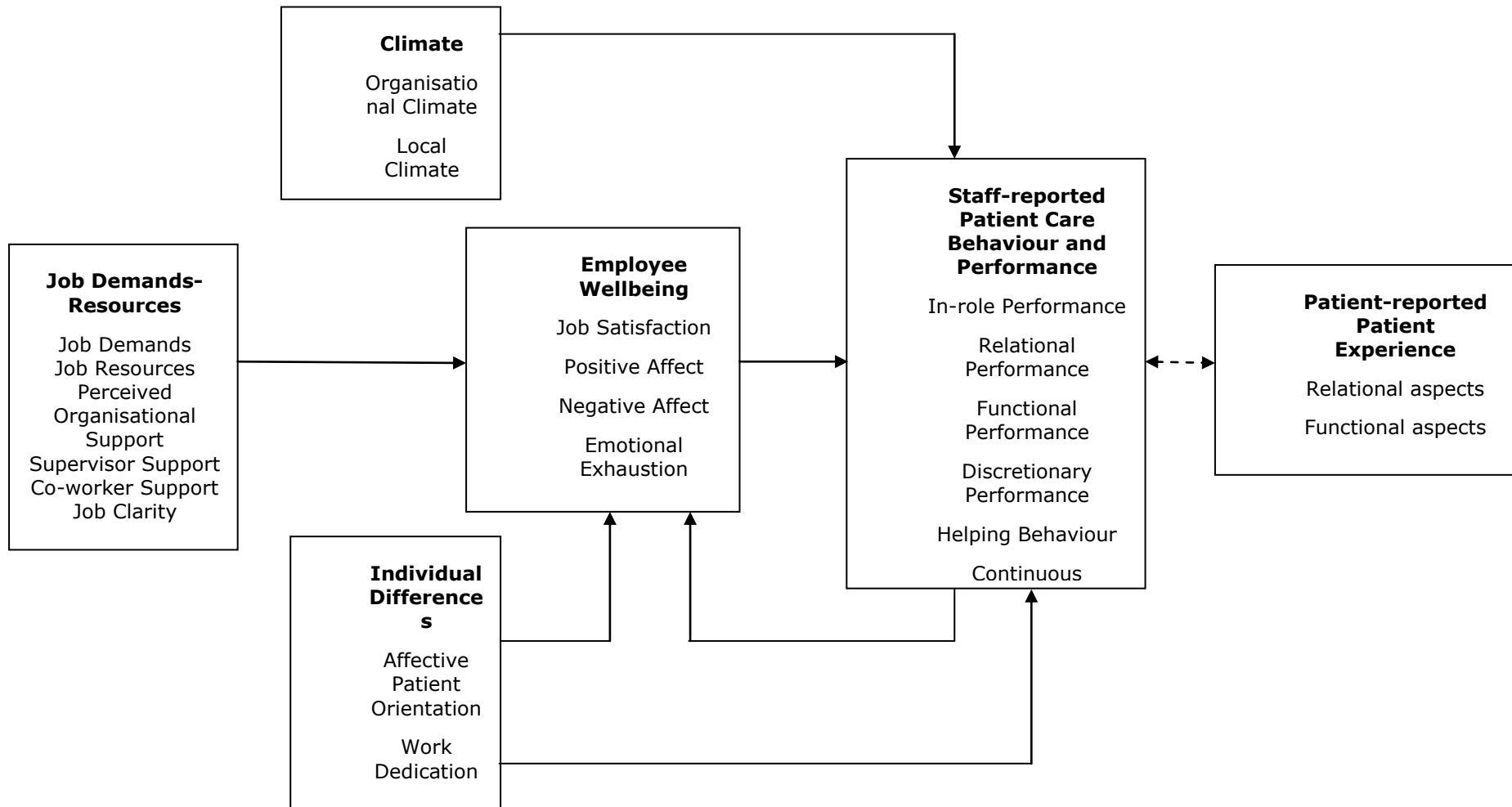
We will return to these high impact actions in our final chapter following presentation of our findings.

Part II: Research Framework

Against this background we now present the overall framework that underpins the study and, in particular, the general model that helps to inform the quantitative part of the research. The research framework, shown in the model in Figure 3, draws on elements of the literature review presented above, as well as on key additional strands of the broader organisational behaviour (OB), organisational psychology (OP) and service quality (SQ) literatures dealing with two core issues that are central to the present project. As noted, a central aim of the present study is to examine the relationship between employee wellbeing and the provision of high quality care to patients. Specifically, the aim is to examine the extent to which the patient-care behaviour and performance (PCBP) of employees is affected by their experienced sense of wellbeing at work. To the extent that wellbeing affects high quality patient care, it is then important to examine possible drivers of wellbeing at work. A secondary aim of the project, therefore, is to identify key potential antecedents of employee wellbeing. The model shown in Figure 3 is designed to capture these two aims.

In the following discussion we selectively draw on important strands of the OB, OP and SQ literature to identify, first, core possible antecedents of employee patient care behaviour/performance and, second, key drivers of wellbeing at work. In our overall framework we also consider the association between these antecedents and drivers with patient-reported patient experiences which we conceptualise as comprising both relational and functional aspects (see Section 2.3.2 above).

Figure 3. Research framework



2.5 Basic research model: Antecedents of patient care behaviour/performance

As noted, our primary interest is in the relationship between employee wellbeing at work and employee patient-care behaviour and performance. However, there are a number of other factors, apart from wellbeing, that may affect employee behaviour towards patients. As we discuss more fully below, the broader OB, OP and service quality literatures suggest that there are two sets of factors that are particularly important in this respect. The first set of factors relates to the climate for patient care in the organisation. This refers to the extent to which high quality patient care is emphasised and given priority at various levels in the organisation. The second set of factors relate to individual characteristics and orientations of employees including, for example, the extent to which they enjoy dealing and interacting with patients, their level of commitment and dedication to their work, and their level of job skills and competence. A key objective of the present study is not only to examine the relationship between wellbeing and patient care performance, but also to explore the importance of wellbeing as an antecedent of patient care behaviour relative to other key potential antecedents of PCBP.

This focus is reflected in the hypothesised immediate antecedents of patient care behaviour and performance shown in the model in Figure 3. Central to the model is the idea that there are three main sets of factors that are likely to have a direct effect on employee PCBP. These are (1) various aspects of employee wellbeing at work (wellbeing factors), (2) various aspects of the climate for patient care in the organisation (situational factors), and (3) various characteristics of individual employees (individual difference factors). Below we examine each of these factors and their hypothesised links to PCBP in turn. We start, however, with a brief discussion of the notion of employee patient care behaviour and performance itself.

2.5.1 Employee patient care behaviour and performance

A useful way of thinking about the behaviour of employees towards patients and, in particular, about the level and quality of care that employees provide to patients, is as an aspect of their job performance specifically related to patients. In other words, a useful way to conceptualise employee patient care behaviour is as a form of (patient-related) job performance.

Seen from this perspective, and drawing on the broader OB, OP, and SQ literature, it is then possible to identify two main forms of patient care performance, in-role or task-related patient care performance and contextual or discretionary patient care performance. These two forms of performance are in line with the debates about the patient experience and with the distinction between relational and transactional aspects of patient care from the health care literature reviewed above. Specifically, in-role performance refers to performance in various tasks that are considered to be a normal and integral part of employees' job (242). Drawing on the SQ

literature, it is possible to distinguish between two main aspects of in-role performance, relational and functional performance. Which broadly correspond to the 'relational' and 'transactional' aspects of patient care identified in the health-related literature (99) discussed above.

Relational performance refers to performance linked to the more interactive aspects of the job and the extent to which employees are able to satisfy patient/customer expectations in the way they relate to them emotionally and deliver their services to them (129, 243). In the context of patient care, relational performance would include, for example, how effective employees are at comforting patients in distress, or at relieving patient's fears and anxieties, or at providing emotional support to patients. In contrast, functional in-role performance refers to the extent to which employees fulfil key technical and functional tasks that are a central part of their job effectively and provide the expected service in an efficient and functional manner (243, 244). In terms of patient care this would include, for example, helping patients to manage and control pain, arranging transfer of patients to other services, or helping to coordinate care and support from other services effectively.

Contextual or discretionary performance, on the other hand, refers to the extent to which employees engage in positive and desirable behaviours at work that are not explicitly required by their job or set out in formal job descriptions (242). Discretionary performance can take many forms including, for example, various forms of organisational citizenship (29, 245, 246) and prosocial (247) behaviour, such as helping co-workers with their work duties, providing support for supervisors and championing the organisation to outsiders.

Our interest here is in discretionary behaviour specifically related to patients. Drawing on the literature on customer-oriented behaviour (e.g. Peccei & Rosenthal, 2001) (49) and on prosocial and altruistic behaviour in organisations (247), we distinguish two main forms of discretionary patient care behaviour. The first covers various forms of helping behaviours that go beyond job requirements, such as employees going out of their way to help patients, or doing more for patients than is formally required of them. The second form of discretionary behaviour refers to the extent to which employees engage in continuous improvement activities for the sake of patients (49). These continuous improvement behaviours are outside of normal job descriptions and may include, for example, making suggestions on how to improve patient care in a given work unit, or thinking of better ways of delivering care to patients.

In brief, in the present study and, in particular, in the quantitative part of the research, we explicitly focus on four main forms of patient care behaviour and performance. These include relational and functional patient care performance, as part of in-role performance, and helping behaviours and continuous improvement behaviours in relation to patients, as part of discretionary or extra-role performance.

By conceptualising desirable forms of patient care behaviour in performance terms it is then possible explicitly to link the analysis of PCBP to more general theories of job performance and citizenship behaviour from the OB, OP and SQ literatures. In line with classic models of job performance (248, 249) and citizenship behaviour (246), the main types of in-role and discretionary patient care performance identified above can be said to be a function of two key factors. These are employees' willingness to perform in relation to the different aspects of both in-role and discretionary performance and their capacity to do so, i.e. their willingness and capacity to engage in appropriate behaviours linked to each main aspect of performance. In turn, we hypothesise that employees' willingness and capacity to perform is influenced by the set of wellbeing, situational and individual factors identified in the model in Figure 3. Below we consider each of these factors, and their expected links to patient care performance, in turn.

2.5.2 Wellbeing – Patient care performance relationship

Following Warr (16), work-related wellbeing can be defined as an individual's subjective experience and functioning at work. In the literature, two main dimensions of wellbeing are commonly identified (19). The first dimension refers to individuals' subjective experiences at work including, for example, various aspects of job satisfaction, and both positive and negative work-related affect. The second dimension refers to psychological and physiological aspects of employee health at work including, for example, job-related stress, anxiety, burnout and exhaustion (13, 22). Our interest is in the effect on patient care performance on both the subjective experiences and health-related dimensions of wellbeing.

In the quantitative part of the research we focus on four main indicators or aspects of work-related wellbeing. These are employees' overall job satisfaction, their level of both state positive and state negative affect at work (250), and their level of emotional exhaustion (25). Job satisfaction is considered a core indicator of employee positive wellbeing at work and refers to 'a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences' (20). State positive affect refers to the extent to which individuals experience positive moods and emotions at work, such as feeling optimistic, enthusiastic, calm and cheerful (21, 250, 251). State negative affect, on the other hand, refers to the extent to which individuals experience negative moods and emotions at work, such as feeling worried, depressed, uneasy and tense (21, 250, 251). Finally, emotional exhaustion, which has increasingly come to be regarded as the core dimension of burnout (23, 24), refers to the feeling of being overextended and depleted of one's emotional and physical resources (25).

In terms of the relationship between wellbeing and various aspects of job performance, there is a large body of theoretical and empirical work in OB and OP that has examined this link. The theoretical arguments advanced in this broader literature provide a useful basis for examining the relationship between employee wellbeing and the various aspects of patient care performance that are the focus of the present study. Below, therefore, we

briefly highlight some of the key theoretical explanations of the link between wellbeing and individual job performance that have been proposed in the extant OB and OP literature.

One of the most common explanations of the impact of wellbeing on job performance is in terms of social exchange theory (252) and the norm of reciprocity (253). These social exchange-based explanations are associated, in particular, with inducements-contributions interpretations of the employment relationship (254, 255) and with early versions of the happy-productive worker thesis (256). Central to this explanation is the idea that employees who, because of positive treatment from the organisation, are satisfied with their jobs and enjoy high positive affect at work, are more likely to repay the organisation by working hard and engaging in various forms of discretionary effort (29, 246). In other words, wellbeing, through processes of social exchange and reciprocity, enhances employees' willingness and motivation to engage in both in-role and discretionary behaviours, and hence can be expected to have a generally positive effect on patient care performance.

An alternative explanation of the link between wellbeing and job performance is in terms of Fredrickson's (257) broaden-and-build (B&B) theory of positive emotions. B&B theory, which has attracted increasing attention in recent years, suggests that positive emotions, such as interest, joy and contentment, broaden awareness and promote discovery of novel and creative ideas and behaviour. In turn, this helps to build individuals' physical, psychological, intellectual and social resources which can then be used for more effective coping and survival. Hence, positive affect can be expected to contribute to both in-role and discretionary performance by enhancing individuals' capacity to cope with job demands, stimulating problem-solving and heightening search and creative behaviour. These arguments are consistent with earlier propositions by Isen and his colleagues (258) suggesting that positive emotions can stimulate job performance by enhancing creativity, flexibility, cognitive integration and efficiency of thought. They are also consistent with 'feeling good-doing good' arguments (247) suggesting that individuals who experience high positive affect, partly in order to maintain their current positive mood, are more likely to engage in altruistic and helping behaviours (259).

A parallel set of arguments concerning the link between wellbeing and job performance focuses more explicitly on the negative effect of burnout and, in particular, of emotional exhaustion, on work performance. Drawing on Hobfoll's (260) conservation of resources (COR) theory, researchers have argued that emotional exhaustion, unlike positive affect, undermines and depletes the physical, psychological, intellectual and social resources of individuals at work (261-263). Exhaustion, therefore, can be expected to reduce both individuals' motivation and capacity to engage in desirable in-role and discretionary behaviour at work, thereby having a generally negative effect on job performance.

In this context it is important to note that the link between negative affect and performance may be more complex than that between performance and

either positive affect or exhaustion. A number of researchers have argued that unpleasant affective states can motivate individuals to engage in helping behaviours as a way of feeling better about themselves and reduce their negative feelings (264). The performance consequences of negative affect may not, therefore, just be the opposite to those of positive affect. In particular, negative affect, like positive affect, may help to enhance prosocial and altruistic forms of behaviour at work.

There are two general points to note about the theoretical arguments outlined above. First, despite the force of the arguments involved, the evidence about the effects of the various aspects of wellbeing on individual job performance is not as strong as might be expected. Although generally positive, the relationship between job satisfaction and various aspects of in-role and discretionary job performance, for example, is somewhat varied and is not consistently strong across studies and situations (26, 265). Similarly, the relationship between emotional exhaustion and performance, although generally negative, is not always significant (24). Much of this evidence is, in any case, based on cross-sectional studies, making it difficult to draw clear conclusions about the causal order between exhaustion and performance.

Second, there is still considerable debate about the order of causality between wellbeing and job performance. In the case of job satisfaction, for example, it is uncertain whether, at the individual level, satisfaction is an antecedent or an outcome of performance (26). As argued by Locke (20), for example, employees who perform well in their job are likely to be more highly rewarded and to receive more positive treatment from the organisation, thereby suggesting that satisfaction may be as much a consequence as an antecedent of in-role and discretionary performance. Similarly, while emotional exhaustion may impair performance, it is also likely that individuals who put a great deal of effort into their job and achieve high levels of performance will experience higher levels of exhaustion at work. In other words, exhaustion may be a consequence, and not just an antecedent, of performance; suggesting a positive rather than a purely negative association between exhaustion and performance.

Despite these caveats, based on the theoretical arguments outlined above, as well as on the weight of extant evidence, we expect job satisfaction and positive affect to be positively related to in-role and discretionary patient care performance, and negative affect and emotional exhaustion to be negatively related to both dimensions of patient care performance. This is reflected in the hypothesised relationship between the wellbeing variables and the different forms of patient care performance shown in the model in Figure 3.

2.5.3 Patient care climate - Patient care performance relationship

The second set of factors included in our model as potential antecedents of patient care performance relate to aspects of the climate for patient care in the organisation. In the organisational literature, climate is commonly said to refer to employees' perceptions of their work environment, including their

perceptions of the formal and informal policies and procedures used in the organisation (50, 266). Within this broad definition, a distinction is then commonly made between psychological and organisational climate. Psychological climate refers to individuals' own personal perceptions of their work environment (267-269). Organisational climate, on the other hand, refers to employees' shared perceptions of their work environment (268, 270).

Our focus here is on psychological climate. In particular, our interest is in the climate for patient care in the organisation. This refers to the extent to which employees perceive the organisation, through its policies and practices, and through the behaviour of its agents (e.g. managers and supervisors), to emphasise and give priority to high quality patient care. A clearly focused climate of this kind can act as a so-called 'strong' situation (271), providing clear cues and signals to employees about desired behaviours towards patients. Several studies have shown, for example, that so-called 'climates for something' (e.g. for customer service) (272) can have a significant effect on employee behaviours in that specific area. Safety climate perceptions, for example, have been shown to be positively related to safety compliance (273), while a positive service climate has been shown to be positively related to employee service performance (274). In other words, a strong climate for patient care can be expected to contribute to patient care performance by providing clear signals to employees about what specific patient care behaviours are expected, supported and rewarded in the organisation.

In large complex organisations climate may well vary across organisational sub-units. For example, the emphasis that is placed on high quality patient care performance may vary across work groups or wards. Hence, employee perceptions of the climate for patient care at local level may differ from their perceptions of the climate for patient care in the organisation as a whole. Hence, when considering the impact of patient care climate on employees' job behaviour and performance, it is important to take into account not only their perceptions of the overall climate of the organisation, but also their perceptions of the climate at local level. Here, therefore, we extend the analysis of climate to cover also the local level. In particular, we look at the extent to which individuals perceive their immediate co-workers to be patient oriented and to put a lot of emphasis and effort on providing high quality care to patients. We refer to this variable as work group or local climate for patient care. As shown in Figure 3, we expect both the organisational and the local climate for patient care to have a positive influence on employee patient care performance.

2.5.4 Individual characteristics-patient care performance relationship

The last set of antecedents of PCBP in our model includes three main individual difference variables. The first of these variables is employees' affective patient orientation. Drawing on the SQ literature (44), this variable refers to the extent to which employees find intrinsic satisfaction and

enjoyment from dealing and interacting with patients and contributing to their wellbeing. In line with basic theories of intrinsic motivation (275) and affective action (276), employees with a strong affective orientation to patients can be expected to exhibit higher levels of patient care performance. The satisfaction they derive from interacting with patients and contributing to their wellbeing means that they are likely to put particular effort into various form of direct helping behaviour and relational performance. Indirect support for a positive effect of affective patient orientation on job performance comes from the SQ literature dealing with the antecedents of customer-oriented behaviour. In particular, Peccei and Rosenthal (49, 277) and Grondfeldt (51) found a strong positive relationship between employee affective orientation to customers and their level of customer-oriented behaviour, including both helping and continuous improvement behaviours towards customers.

The second individual difference variable in the model is employees' dedication to their work. Work dedication is one of the three core dimensions of work engagement (278) and refers to 'being strongly involved in one's work, and experiencing a sense of significance, enthusiasm, inspiration, pride, and challenge' (279). Dedication has been shown to have a significant positive effect on job performance in a variety of contexts, including health (280). One important reason for this positive effect is that, consistent with core arguments from positive psychology (281), dedication not only helps to enhance motivation at work, but it also helps to sustain and focus effort, thereby contributing to both in-role and discretionary performance. We expect these positive effects of dedication to operate also in terms of patient care behaviour and performance.

The final variable in our model relates to employees' overall level of skills, competence and experience. As emphasised in standard models of performance (248, 249), and confirmed in a range of studies (26, 248), employees' knowledge, skills and ability is central to performance because it directly affects their actual capacity to perform. However, knowledge, skills and ability are also important because they can enhance individuals' sense of self-efficacy at work (282), thereby helping to strengthen individuals' confidence and motivation to perform. Once again, we expect these positive effects of skill and competence to apply also to patient care performance including, in particular, various aspects of in-role performance.

Overall, therefore, we expect all the individual difference factors to be positively related to the various aspects of patient care performance (see Figure 3).

2.6 Basic research model: Antecedents of employee wellbeing

We now turn to the antecedents of employee wellbeing shown in Figure 3. There is an extensive theoretical and empirical literature dealing with the antecedents of work-related wellbeing (26, 283, 284). Here we will necessarily be selective in our coverage and focus on three main sets of

potential antecedents. These include, (1) a number of key job demands and resources linked to core employee experiences at work that are widely regarded in the broader OB and OP literature as central to an understanding of wellbeing (job demand and resource factors), (2) various characteristics of individuals (individual difference factors), and (3) various aspects of the past in-role and discretionary performance of employees (past performance factors). Below we discuss each of these set of factors in turn.

2.6.1 Job demands and resources – Wellbeing relationship

Here we draw on an important stream of thinking in the OB and OP literature that focuses specifically on the impact that employee experiences at work have on various aspects of their wellbeing from the standpoint of job demands and resources. Central to this approach is the idea that work experiences, or what are sometimes referred to as perceived working conditions, can directly contribute to the satisfaction of important individual needs at work, such as autonomy, support, belonging and so on. Hence, the quality of employees' day-to-day experiences at work can have a significant impact both on positive (e.g. satisfaction, positive affect) and negative (e.g. emotional exhaustion, negative affect) aspects of their wellbeing. In other words, both positive and negative aspects of wellbeing are directly related to key work experiences including, for example, perceived job demands, job control, social support, role ambiguity, role conflict and distributive justice (28-30, 285). Using the job demands-resources (JD-R) model, these key job attributes and work experiences can usefully be grouped into two broad categories of work-related demands and resources (286). Job resources include factors such as job autonomy, supervisor and co-worker support, and access to information, while job demands include both so-called hindrance demands (e.g. role ambiguity, role overload, role conflict) and challenge demands (e.g. job complexity and job responsibility) (287). Job resources have been shown to be positively related to positive psychological states, such as work engagement, and negatively related to negative aspects of wellbeing, such as burnout. Job demands, on the other hand, and in particular hindrance demands, have been shown to be positively related to burnout, but negatively related to positive psychological states such as engagement (287).

More recently, the JD-R model has been linked to (35, 36) conservation of resources (COR) theory. This has provided a useful means for analysing the effects of work experiences on wellbeing. Hobfoll (34) [p307] defines resources as those conditions that 'either are centrally valued in their own right, or act as means to obtain centrally valued ends' (e.g. job control, social support). Resources are valued by individuals because they enable them to achieve positive outcomes, like better coping and wellbeing. Resources like social support, for example, can help employees to cope more effectively with high job demands or role stress. More generally, COR theory suggests that individuals who possess more resources are more likely to experience positive wellbeing outcomes, such as job satisfaction, and less likely to experience negative outcomes, such as emotional exhaustion (288, 289).

Drawing on the JD-R model (32, 33), in the present study we focus on a number of key work-related demands and resources that theory and research in this area suggest are likely to be central to employee wellbeing. The main demand and resource-related work experience variables involved are shown in the model in Figure 3. As can be seen, in terms of wellbeing, we focus on the three main aspects of wellbeing we examined in the previous chapter, namely, job satisfaction, emotional exhaustion and relative positive affect. These different aspects of wellbeing are, in turn, expected to be affected by a number of job-related demands and resources. The first of the JD-R antecedents is job demands. Our focus here is primarily on quantitative demands, as a key aspect of hindrance demands, which refer to the amount of work that employees have to complete in a limited time (16, 30). Quantitative job demands are sometimes also referred to as 'role overload' or 'time pressure' (290). The second JD-R variable included in the model is job control which refers to the degree of discretion and autonomy employees have in making job-related decisions (28, 30).

The next three JD-R antecedents include various aspects of support at work. The first support variable is perceived organisational support (POS), defined as the extent to which individuals perceive that 'the organisation values their contributions and cares about their wellbeing' (291) [p500]. The other two support variables are supervisor and co-worker support which refer to the extent to which individuals perceive their immediate supervisor and their co-workers, respectively, to be helpful, emotionally supportive and care for their wellbeing (292, 293). The last JD-R antecedent is job clarity which refers to the extent to which employees perceive their job duties and responsibilities to be clear and well-defined (294).

Based on JD-R research and on the COR theory arguments outlined above, we expect the set of JD-R antecedents, with the exception of job demands, to have a positive effect on job satisfaction and on positive affect, but to be negatively related to emotional exhaustion (23, 295-298). In contrast, we expect job demands to be positively related to exhaustion, but to have a negative effect on job satisfaction and positive affect (285, 298, 299) (see Figure 3).

2.6.2 Individual characteristics – Wellbeing relationship

In the present study we extend the JD-R model and COR theory arguments to cover personal resources, in the form of individual work orientations and job skills, as potential antecedents of employee wellbeing. As shown in Figure 3, the specific personal resources we focus on are the three main individual difference factors we identified in the previous section as potential antecedents of employee patient care performance, namely, employee affective patient orientation, work dedication and job-related skills and competence. Consistent with psychological capital arguments and research (37-39), an affective patient orientation, work dedication and high levels of job competence and skills can be seen as personal resources that can contribute to individual wellbeing by enabling employees to cope and adapt more effectively to difficult or stressful work situations. For example, work

dedication can contribute to wellbeing by enhancing individuals' capacity to deal with job demands, while high levels of skills can help individuals to cope more effectively with job-related problems and challenges. Other things equal, therefore, the three individual level variables in our model can all be expected to have a beneficial effect on wellbeing (see Figure 3).

2.6.3 Past performance – Wellbeing relationship

As noted above, there is considerable debate in the literature about the direction of the relationship between employee wellbeing and job performance (26). For example, emotional exhaustion, like job satisfaction, may be both an antecedent and a consequence of job performance. To explore the possibility of reverse causality between wellbeing and job performance, we included the various aspects of in-role and discretionary performance outlined above as potential antecedents of wellbeing (see Figure 3).

2.7 Summary: linking patient experience and staff wellbeing

As reviewed above, associations have been reported between job satisfaction and performance and absenteeism of health workers (42), nurses' job satisfaction and patient satisfaction (205, 216), nurse stress and patient satisfaction (300) and in acute care, medication errors and falls (208). Much of the evidence comes from North America and reviews have suggested methodological weaknesses (42, 301). In the UK few studies have demonstrated links between stress and burnout and their effects on patient care. Linking staff satisfaction, stress or burnout to patient outcome or satisfaction data in large data sets is also problematic and research has often been cross sectional and staff and patient data have not been directly linked. Thus what has not been conclusively demonstrated is the link between staff motivation and wellbeing and patient satisfaction and quality of care (42) (and the processes whereby that link is established and sustained). The links between staff wellbeing, affect, motivation and patient care are multi-faceted and are best examined over time using a flexible combination of both quantitative and qualitative methods.

The links between staff motivation and wellbeing and patient experiences of care are also likely to be complex and processual. Such processes are expected to be shaped not only by the societal and organisational contexts within which interpersonal relationships of care (between staff and patients as well as between staff) occur but also by the broader, shifting, and sometimes discordant, concerns over 'satisfying work' and 'quality care' that circulate through different staff groups; working professionals; individual practitioners and various patients and their formal and informal networks and associations.

There is little UK research that explores the contextual factors that link staff motivation and wellbeing to patients with different care requirements or to patients within different health care settings. The differing clinical and

emotional care needs of patients (167), their anticipated or actual prognosis and, not least, the variable status of patient groups along with their associated specialist staff settings have been shown to have an impact on the work motivations and psychological work reactions of staff (174, 302). Although research to date has shed light on the different qualities of experiences amongst different staff, there has been no consideration of how patient's expectations and experiences of care contribute towards these settings.

This study set out to address these deficits through linked patient and staff data and through a combination of methods including patient and staff interviews, panel surveys and direct observation of practice. We therefore undertook a 30 month, multi-method study with in-depth ethnographic methods and additional quantitative measures, using case studies of eight different clinical microsystems in four different NHS organisations (two in the acute sector and two in the community sector). The quantitative part of the study was guided by the summary framework shown in Figure 3 and was informed by both the general and the more targeted literature reviews presented above. We included a range of staff in our study because it matches more closely a patient's experience - an experience of the whole, not discrete staffing groups. Before describing our methods (Chapter 4) and presenting our findings (Chapters 5-9) we set out the specific aims and objectives of our study (Chapter 3).

3 Aims and objectives

In this three-year study we sought to explore the links between (a) patients' experiences of health care, and (b) staff motivation, affect and wellbeing.

In order to better understand this complex set of relationships our specific study objectives were to:

1. Identify and analyse attitudes and behaviours of staff described by patients as shaping their experiences that may connect with, and be influenced by, staff wellbeing.
2. Determine which particular staff attitudes, affect and behaviours impact on patients' experiences of care.
3. Explore how staff experience work and how this influences their affect, motivation and capacity to deliver high quality care
4. Identify how context, including different types of organisational arrangements, culture or climate contribute to staff wellbeing and patient care.
5. Explore with staff the issues of emotions at work, emotional labour and customer orientated care.
6. Identify ways to enhance the experience of patients and the wellbeing of the healthcare workforce.

4 Methods

This chapter briefly summarises the overall research design and methods used to address the six study objectives in Chapter 3.

4.1 Overall study design

Our mixed-methods research design comprised multi-level case studies that allowed both the comparison of two microsystems within each of four organisations and the comparison of these eight microsystems across the four different organisational contexts (303). The research was undertaken in two phases (see Figure 4 below).

In Phase I of the study four health care organisations were identified as case study sites. The four organisations were purposively selected based on nationally available routine data (CQC ratings, national patient survey and national staff survey results) to provide a 'high' and 'low' performing organisation with regard to staff wellbeing and patient experience in both the acute and community care sector (see Figure 4 and Table 5 below). Fieldwork began with one-to-one tape recorded interviews with senior operational and clinical managers in each of the four organisations in order to explore the context for staff wellbeing and patient experience in each (see Appendix 9 for interview schedule).

From a combination of a comparative analysis of routine data within these four organisations and the interviews with senior managers, two services or clinical microsystems were then identified for in-depth qualitative and quantitative fieldwork. As with the purposive selection of the four organisations we sought to identify a 'high' and 'low' performing microsystem within each organisation. In addition, two focus groups with members of a Patients Council (not associated with any of the case study sites) were conducted in order to establish the extent to which patients and carers are able to make associations between their personal experiences and issues relating to staff wellbeing (for example, behaviours in staff that could have wellbeing as an antecedent, or behaviours that patients felt exhibited signs of staff affect, stress etc).

In Phase II of the study data collection in the eight 'embedded' microsystems comprised:

- a staff wellbeing survey (see Appendix 10)
- a patient experience survey (see Appendix 14)
- interviews with staff (see Appendix 16 for interview schedule)
- interviews with patients or patients and carers (see Appendix 17 for interview schedule)
- non-participant observation of staff working practices and interpersonal interactions with patients.

4.1.1 Microsystem definition

A microsystem in health care delivery can be defined as a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, shared information environment and produces performance outcomes. They evolve over time and are (often) embedded in larger organisations.

There is an increasing evidence-base relating to the factors that influence how 'improving quality' can be successfully implemented and assimilated into the routine practice of front-line clinical teams. Such work has been heavily influenced by the microsystems focus in the work of researchers from Dartmouth-Hitchcock in the United States (304, 305). Healthcare organisations might not be utilizing the term microsystem, but it is clear that many high quality and cost-efficient providers are organizing themselves around functional front-line teams & professionals that have the right information at the right time, to deliver the best care possible (306-309). However, given that each of the macro (national healthcare system), meso (hospital) and micro (front-line clinical team) levels, separately and in interaction with each other, affects clinical effectiveness, patient safety and patient experience our study places a particular focus on the dynamics and interactions between these different levels (310-312).

Figure 4. Research phases and project timeline

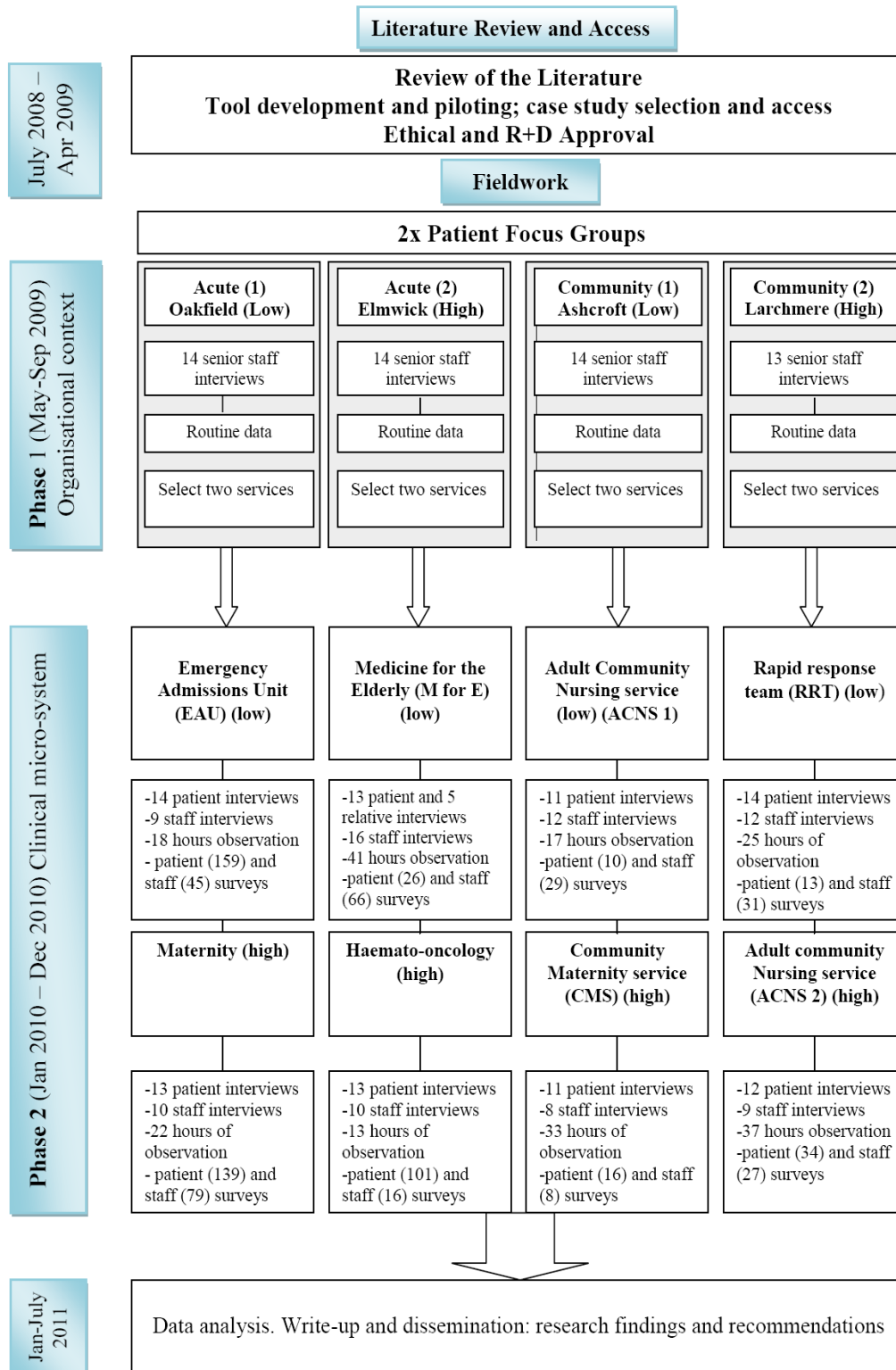


Table 1 indicates how the different methods contributed to each of our study objectives.

Table 1. Aims and methods of study

Objective	Phase I		Phase II				
	Patient focus group	Senior mgr int	Patient Int	Patient survey	Staff int	Staff survey	Observation
Identify factors shaping patient experience that may connect with, and be influenced by, staff wellbeing	✓	✓	✓	✓	✓	✓	✓
Determine which staff attitudes, affect and behaviours maximise patients' experiences of care	✓	✓	✓	✓	✓	✓	✓
How staff experience work and how it influences their affect, motivation and capacity to deliver high quality care			✓		✓	✓	✓
Establish contextual factors shaping working lives and patient experience		✓	✓	✓	✓	✓	✓
Examine issues of emotions at work, emotional labour and customer orientated care with staff	✓		✓		✓	✓	✓

The design of the suite of research instruments was guided by the research objectives and the literature review, but was also cognisant of the practical challenges of conducting in-depth fieldwork over several years in busy and overstretched NHS organisations. The advice of advisory group members and participating trust leads informed our approach to accessing, sampling and addressing the practicalities of undertaking the fieldwork. Our two patient representatives on the project advisory group were also asked for insights and comments relating to patient involvement in the study. As a result some changes to the original study design were made and at various stages in the research process applications were made to the funders, the

NIHR SDO, who approved all proposed changes to the study design. Table 2 below details the amendments to the original study design.

Table 2. Amendments to the original study design

Original Intention	Revised intention / Reason for change	Amended process
Phase I: To interview patients across England with a range of health experiences and conditions and where possible staff who work in the same areas	To ensure direct link between staff and patients and their managers in organisational case studies	Sampling of 8 microsystems within 4 organisational case studies to facilitate within and between case comparisons. Phase I data now includes patient focus groups and interviews with senior managers in the four case studies to provide insights into links between staff wellbeing and patient experience.
Phase II: to have four case studies in 2-4 acute/ primary healthcare trusts	To enhance the study design and increase rigour by having 2 microsystems within each organisational case study (allowing for intra- and inter- organisational comparisons)	Increased the number of microsystems from 1 to 2 in each organisation, doubling the number of microsystems from 4 to 8.
Phase I organisational case study sample to include primary care	Access very difficult: despite approaching 3-4 organisations we did not get approval, and advisory group suggested focusing on acute and community sites only	No primary care case studies. Two acute and two community organisational case study sites were included in study sample.
Phase II: Use of routine data in case studies	Data gathering difficult in community settings and lack of comparability of time periods / settings and data type meant data less meaningful	No routine data reported in case studies.
Phase II: Use of patient and staff diaries	Piloting with staff did not capture aspects of the psychological contract for staff as hoped, and NHS staff reported lack of time to complete (over 10 days). Patients also too sick, frail or not in service long enough to complete over 5-10 days	No diaries fielded with staff or patients. We increased patient and staff interviews and observation data to compensate.

4.2 Patient and public involvement

From the outset of this study service user (patients, carers and the public) involvement was seen as essential to planning and designing the research. This had the potential to shape the research questions according to issues that matter to patients and to develop appropriate methods to explore patient experience. The rationale for involving service users in this particular study was that they would be able to put forward patient perspectives and contribute to the research process. The knowledge, understandings and focus of professional researchers and healthcare professionals can differ from what is considered important or most significant to patients. We were committed to the idea that patient perspectives should have a central role in defining the meaning and scope of what constitutes patient experience of care.

Service user involvement in the study can be perceived as occurring at two levels:

- Collaboration (membership of the steering group)
- Consultation (patient focus groups in Phase I, and patient involvement in Phase II at the case study sites).

Because of the large scope of this study and the focus on links between staff motivation and wellbeing and patient experiences of care it was appropriate to use two levels of involvement for a number of reasons. First, we wanted to gain patient perspectives on the topic of the research, the concepts under consideration and the methods of investigation. This required involvement on the project steering group from an 'experienced' service user representative (Brearley). Through this advisory role patient perspectives were represented in identifying the research questions, selecting the research methods, commenting on questionnaire design, data analysis and dissemination.

Second, we wanted to gain 'authentic' accounts of patient experiences at the point of care delivery. Thus, capturing direct experiences of care was an important deciding factor in decisions about the approach (focus groups) and the level (consultation) of service user involvement. We chose an overall ethnographic approach because this would enable the field researchers to 'get close' to patients and to hear their experiences first hand (rather than through indirect methods, for example professional's accounts of patient experience, or through the use of post-care questionnaires only). Although consultation is generally perceived as representing a low level of service user involvement, using an ethnographic approach and multiple methods (interviews, focus groups and observation) helped to bring a wide range of patient perspectives to the research.

During data collection service user involvement was important for drawing attention to the ethical considerations and how these were managed. For example ethical issues relating to the involvement of users in research included accounting for times of fatigue and the emotional demands of

conveying personal stories of care. Consultation with service users within care settings helped to sensitise the field researchers to the complexity of patient experiences of care – as well as providing a view into the realities and close relationships between staff motivation and wellbeing and patient experiences of care. In particular, service user involvement helped to support the management of ethical issues; by adequate provision of information about the research and what would happen with information provided to the field researcher. There was also the important and sensitive issue of patients who were actively receiving care being asked to comment on the experience of care provided by healthcare professionals. Using consultation methods within an ethnographic approach enabled the field researcher to gain information from patients whilst protecting their confidentiality.

The main methodological consideration raised by our approach to service user involvement was the potential impact on the quality of the data. To manage this issue we purposely considered different interpretations of the qualitative data i.e. healthcare professional perspectives, managerial perspective, patient perspective. Coding structures and emergent themes were negotiated and reviewed by members of the research team and members of the steering group to ensure meaning was not misinterpreted by any one perspective.

Given the important role that service users have in contributing to the improvement of health services and health research, it is important to reflect on the impact of involvement in this study and to suggest ways for effective involvement in future research. Later in the report we look at the impact of service user involvement on the research, the people involved in the research, and the wider social impact (Section 10.3.3). In particular we highlight insights gained about issues and approaches to involvement in the context of research on patient experiences.

There are important messages for patients, carers and relatives from this research and for patient and carer organisations. These are explained in sections 10.7 and 10.8 of the report.

4.3 Phase I fieldwork

4.3.1 Focus groups (April 2009)

The focus groups were intended to explore two questions related to the broad aims of the research study. These were (a) which particular staff attitudes, affect and behaviours impact on patients' experiences of care and (b) which staff attitudes and behaviours described by patients as shaping their experiences may be connected with staff wellbeing.

4.3.2 Focus group structure and organisation

We accessed and recruited patients through a Patient Council contact in the North of England and invited members of the council to attend one of two focus groups on a particular day. We asked the Patient Council organiser to

recruit patients who would be prepared to talk about their recent interactions with NHS staff and how staff behaviour towards them may or may not have been influenced by staff wellbeing.

One focus group ran in the morning with eight members and another in the afternoon with four members. There was a good range of health issues and age and gender represented across the groups. Each group ran for approx 90 minutes, facilitated by an experienced member of the research team (GR) with support from our PPI lead (Brearley). See Appendix 8 for focus group topic guide. Each focus group was recorded and transcribed and the transcript made available for analysis. JM was present also and took extensive field notes.

4.3.3 Focus group data analysis

Given the purpose of the focus groups, analysis of focus group findings focused on content and category analysis rather than narrative format and paralinguistic behaviour analysis (313) or documentary meaning content analysis (314). The content analysis examines 'what becomes a topic ... and how the topic is treated' [p220] (314) and includes, as far as possible, certain types of narrative, such as questions, anecdotes, censorship, deference and ambivalence (315). Following Bohnsack's guidance the analytical method used for focus group data content and category analysis took three steps. First, the decoding of normally implicit thematic structures to identify thematic composition; second, the restructuring of discourse organisation (including, where relevant, the ways that participants' related to each other); and, thirdly, when possible, the identification of common features, contrasts in common features and specific contrasts between the focus groups and themes emergent in the focus groups.

4.3.4 Site selection (August 2008- May 2009)

Selection of the four case study organisations was purposive, led by the study questions but accommodating the pragmatics of large scale national research work. For example, we knew that the engagement required would need to be significant to sustain the project over 30 months, and all else being equal, we were keen to go where the energy for engaging with the research was high. However a number of sampling criteria were used including:

- a range of community and acute trusts
- trusts with different geographical spread and challenges (urban / rural; large / small geographical spread)
- Foundation and non Foundation trust status;
- a range of high and low performing organisations in terms of national patient and staff survey results.

Discussions were initiated with a number of NHS acute trusts (n=4), primary care trusts (n=3) and community provider services (n=3). We were keen to identify organisations which were either doing well or struggling in either (or both) staff wellbeing or patient experience. Thus some organisations agreed to participate because representatives considered their

organisations to be particularly high or low achieving in annual NHS survey reporting on staff or patient satisfaction indicators. Some organisations we spoke to felt they had initiatives underway either relating to staff wellbeing or patient experience or had a mixed record of achievement according to these indicators and were keen to explore these issues. This was particularly so in community provider services, where routine survey and reporting on patient satisfaction or experience was absent, organisational representatives were often keen to learn from the research data. Some organisations, and this was particularly true of primary care, felt that there would be considerable upheaval following the 2008 Darzi review in primary care, meaning a potentially unstable research environment with organisational mergers etc. It was therefore decided with advice from the project advisory group not to pursue a primary care trust but to focus on community services.

In this report we have created pseudonyms for each of the four NHS trusts (Oakfield, Elmwick, Ashcroft and Larchmere) to protect organisational confidentiality.

The most recent NHS staff and patient survey results (2007-2009) were used to establish direct case study comparisons for initial decision making and first stage analysis. Selected NHS national survey findings of patient satisfaction and experience (for acute trusts Oakfield and Elmwick only) are shown in Table 3 whilst selected NHS national survey findings indicative of staff wellbeing and available for each of the four case study sites are provided in Table 4.

Table 3. In-patient survey results for selected items (2008 & 2009 results)
(scored out of 10)*

	Oakfield			Elmwick		
	2007	2008	2009	2007	2008	2009
Did you have confidence and trust in the doctors treating you?	8.6	8.7	8.6	9.1	9.2*	9.0
Did you have confidence and trust in the nurses treating you?	8.5	8.7	8.4	8.3	8.6	8.3
Were you involved as much as you wanted to be in decisions about your care?	6.9	6.9	7.0	7.4	7.4	7.2
Did you feel you were treated with respect and dignity while you were in the hospital?	8.7	8.9	8.4	8.8	9.0	8.9
Overall, how would you rate the care you received?	7.5	7.7	7.4	7.8	7.9	8.0

* Bold type indicates better than NHS median score

The annual NHS in-patient survey results above show that Elmwick scored higher than Oakfield on measures such as 'overall' patient ratings of their care, being treated with 'respect and dignity', and involvement in decisions about their care. Elmwick also scored much higher in the Care Quality Commission ratings than Oakfield. It is not possible to draw comparisons between staff and patient satisfaction in the community provider organisations, Ashcroft and Larchmere, because data on patient satisfaction or experience had not been routinely collected for annual national reporting.

We also accessed and examined the annual staff survey findings for the same recent years, with particular attention to questions that may be indicative of staff wellbeing (Table 4).

Table 4. Staff survey results for selected items (2007 -2009)*

	Oakfield			Elmwick			Ashcroft			Larchmere		
	2007	2008	2009	2007	2008	2009	2007	2008	2009	2007	2008	2009
Staff job satisfaction (1-5; 5 = very satisfied)	3.31	3.43	3.45	3.48	3.53	3.54	3.53	3.54	3.49	3.39	3.62	3.64
% staff recommending Trust as place to work	-	43	-	-	68	-	-	45	-	-	56	-
Staff recommend Trust as place of work or receive care (1-5; 5 = high)	-	-	3.25	-	-	3.78	-	-	3.28	-	-	3.58

% staff satisfied with quality of work/patient care they are able to deliver	-	62	71	-	74	78	-	68	64	-	75	73
% staff suffering work-related stress in last 12 months	27	26	26	31	27	25	33	30	36	45	30	29
Work pressure felt by staff (1-5; 5 = high work pressure)	3.24	3.18	3.23	3.19	3.08	3.08	3.26	3.25	3.28	3.48	3.06	3.08

* Bold type indicates better than NHS median scores for acute trusts and PCTs; italic type indicates worse than NHS median scores for acute trusts and PCTs.

In the acute trusts (Oakfield and Elmwick) in 2009 Oakfield's scores placed it in the worst 20% compared to trusts of similar type for work pressure felt by staff and for 'staff recommendation of the trust as a place to work or receive care'. In 2009 Elmwick's scores placed it in the best 20% compared to trusts of similar type for the 'percentage of staff feeling satisfied with the quality of work and patient care they could deliver' and 'staff recommendation of the trust as a place to work or receive care'. There is a notable consistency of 'above' and 'below' average scores for staff survey ratings for both Oakfield and Elmwick over time, suggesting Elmwick was a higher performing trust in terms of staff annual survey responses than Oakfield.

In the community provider organisations (Ashcroft and Larchmere) Ashcroft scored in the lowest 20% of trusts of a similar type for the 'percentage of staff feeling satisfied with the quality of work and patient care they could deliver'; for 'high work related pressure felt by staff'; and for the 'percentage of staff suffering work-related stress in the last 12 months'. In 2009 'staff job satisfaction' had decreased significantly so that the organisation was in the lowest 20% of trusts of a similar type and also for 'staff recommendation of the trust as a place to work or to receive care'. Through this period Larchmere had received scores of average or above average on the same range of selected staff work satisfaction measures. A greater proportion of staff in Larchmere would 'recommend the Trust as a place to work' compared to the national average, a smaller proportion of staff - and below the national average - would do so in Ashcroft. In both community sites staff reported higher than national average 'suffering work-related stress in the last 12 months' however the differences in reported scores between the two sites increased between 2008 and 2009. Nationally, staff reported 'work-related stress' is typically slightly higher in community than acute healthcare settings; a trend apparent in our case study sites.

The national staff survey data for Ashcroft and Larchmere must, however, be treated with caution. As indicated in the table notes above, the national survey results reported on different organisations and different

organisational staff groups as the Transforming Community Services (TCS) agenda progressed, and progressed at varying pace nationally.

Overall, whilst we felt there were some significant differences between the four sites in terms of national survey data, we also knew there would be considerable variation within each of these four trusts so felt confident that we would be able to study staff wellbeing and patient experience within and between these four trusts to answer our study aims and objectives. Thus overall from the NHS staff and patient survey results for 2008-2009 when we commenced this study the trusts appeared to be in the following position relative to each other:

Table 5. Trust positions based on 2008-2009 NHS staff and patient survey results

Type of care provided	High performing	Low performing
Acute	Elmwick	Oakfield
Community	Larchmere	Ashcroft

4.3.5 Senior manager semi-structured interviews (June to December 2009)

In Phase I, empirical data collection began with interviews with senior managers, recruited by purposive sampling (see Appendix 9 for semi-structured interview schedule). The purpose of these interviews was threefold:

- to gain their views on staff wellbeing, its influence on patient experience and perceptions of quality of care
- to identify organisational strategies and initiatives to improve staff wellbeing and/or patient experience
- to identify two clinical microsystems, embedded case studies, for each organisation where the Phase II work would be undertaken.

A 'key link person' for each organisation was identified and continued to work in this role with the research team through Phase I of the research. These 'links' circulated information to managers in their organisations and identified and approached key management staff for interview. Executive, operational and clinical managers were short listed and approached by the research team if they had a particular work remit that included staff wellbeing or patient experience issues. Individuals interviewed were drawn from a cross-section of managerial positions ranging from two Chief Executives (in the acute hospitals) and Managing Directors (in the community health provider services) to clinical tutors and occupational health practitioners (see Table 6).

Table 6. Phase I: senior manager interviewees

Oakfield (Hospital Trust) (n=14)	Elmwick (Hospital Trust) (n=14)
<ul style="list-style-type: none"> • Equality & Diversity Manager • Chaplain • Emergency Care General Manager • Medical Director • Lead of AHPs • Director of Estates & Facilities • Clinical Tutor • Director of Human Resources • PPI Manager • Chief Executive • Deputy Chief Nurse • Chair of Staffside Exec • Planned Care General Manager • Chief Nurse 	<ul style="list-style-type: none"> • Chief executive • Director of PR & Comms • Asst Director of OD • Director of Patient Experience & Public Engagement • Employee Development Mgr • Head of Medical Staffing • Ops Mgr – Medical services • Director of Ops Nursing • Unison, staffside secretary • Deputy Ops Mgr • Asst Dir of Public Engagement • Membership & Patient Experience Mgr • Asst Dir of Organisational Development • Consultant, Occupational Health
Ashcroft (Community Provider Organisation) (n= 14)	Larchmere (Community Provider Organisation) (n=13)
<ul style="list-style-type: none"> • Director of Community Health Services • Assistant Director of Nursing and Workforce Planning • Head of Community Nursing • Head of Patient Quality and Safety • Assistant Director of Adult Services [1] • Assistant Director of Adult Services [2] • Assistant Director of Children’s Services • Nurse Consultant (Specialist Conditions) • Nurse Consultant (Specialist Conditions) • Nurse Consultant • Head of Specialist Community Nursing • Clinical Lead Nurse for General Practitioners • Assistant Director of Human Resources (Employment Relations) • Occupational Health Practitioner 	<ul style="list-style-type: none"> • Managing Director of Community Services • Acting Lead for the ‘Transforming Community Services’ Agenda and Unison Staffside representative • Head of Innovation and Improvement • Head of Patient Quality and Safety • Head of Adult Services • Head of Children’s and Young People’s Services • Assistant Director of Human Resources • Occupational Health Senior Nurse • Service Matron for Children’s Services • Clinical Lead for Adult Nursing Services • Clinical Lead for Adult Nursing Services • Clinical Lead for Adult Nursing Services • Clinical Lead for Adult Nursing Services

In total we interviewed 55 National Health Service managers from two large acute hospitals (n=28) and from two community health provider services (n=27) located in regions of England.

Managers who agreed to be interviewed signed formal consent forms and had the opportunity to read the information sheets and ask questions of the research team. Interviews with managers from the four case study organisations were undertaken independently by two researchers from the research team (GR and MA). Interviews were conducted in Oakfield and Elmwick acute trusts in May and June 2009 and in community trusts Ashcroft and Larchmere between July and September 2009. Each interview lasted between 45 minutes and 75 minutes and was conducted on a one-to-one basis with open-ended questions and conversational in style.

Interviewees were guided by a topic guide (Appendix 9) covering the nature, purpose and responsibilities for staff wellbeing and on the interconnections between staff wellbeing and patient experience. Interviews were audio-taped, anonymised and transcribed into a word document for analysis.

4.3.6 Manager interview data analysis (Phase I)

The manager interview transcripts (n = 55) were analysed through a series of general and focused readings by two members of the research team. This analysis was to identify emergent categories from which patterns and 'high frequency' themes could be established (316). In addition, a random selection of complete transcripts were reread as 'personal case-studies': interviewees views were interpreted alongside available information on their employment, professional and personal histories and situation. These 'personal case-study' readings were undertaken to lessen the risks of the loss of storylines through thematic fragmentation (317).

4.4 Phase II fieldwork (January – October 2010)

In Phase II in-depth ethnographic methods (semi-structured interviews and non-participant observation) and quantitative data collection (by patient and staff questionnaire surveys) were undertaken in two selected clinical microsystems within each of the four case study organisations (see Figure 3). The data collection undertaken in each clinical microsystem is described in the sections below. In each of the eight microsystems we explored

- the nature of associations between staff wellbeing and patient experience within front-line services, and
- how the wider organisational contexts identified in Phase I, and the particular policies and strategies in each site, impacted on both staff wellbeing and patient experience.

4.4.1 Sampling of case study microsystems

As outlined above all senior managers in Phase I of the study were asked at interview to nominate an area that they considered had either (or both) high patient experience and/or high staff wellbeing and also an area with low staff wellbeing and/or low patient experience. The nominations and results of this exercise were charted by the research team in order to select a relatively high and low performing service in the two acute and two community trusts. In all four trusts there were areas that were consistently reported resulting in two or three candidates for each category. The research team took these selections to the advisory group with suggested purposive sampling to arrive at our final eight microsystems. These selections were then taken back to our NHS trust colleagues for further refinement and discussion. The sampling aimed to capture a range of ages (maternity and care of older people) and 'dwell' time – emergency admissions and haemato-oncology for example. In the community we sampled to include a range of different community services serving different patient populations and providing care in different ways

(community matron team and rapid response team as well as more traditional community nursing services). Our final sample is outlined in Table 7 below:

Table 7. Eight microsystems

	Elmwick (low)	Oakfield (high)	Ashcroft (low)	Larchmere (high)
High performing	Maternity	Haemato-oncology	Community Matron Service (CMS)	Adult Community Nursing Service (ACNS2)
Low performing	Emergency admissions (EAU)	Medicine for the Elderly (MfE)	Adult Community Nursing Service (ACNS1)	Rapid Response Team (RRT)

4.4.2 Access to the microsystems

Once the microsystems had been identified and selected for Phase II fieldwork, members of the research team made several site visits and engaged in email and telephone communications with key leaders and managers within the services selected. These were information giving and briefing sessions designed to inform the case study sites of the commitment required to participate in the research. No case studies which had been selected based on Phase I data analysis refused to take part but in some settings the access negotiations were re-negotiated on several occasions owing to staff movements, particularly in the community services. Once managers were signed up to the project, members of the research team set up meetings or attended staff and team meetings to brief staff members in the case study settings on the research, to give out information sheets and to answer any questions that arose. The number of these varied per case study but ranged from 2-8.

4.4.3 Non-participant observation of clinical care and organisational practices

Non-participant observations were initiated within the clinical microsystems with the expressed consent of patients, team or service managers and the written consent of the staff involved during that research visit. This research method was useful for several reasons.

- Orientation: it furnished the opportunity for the researcher to become familiar with the environments experienced by staff and patients who were interviewees, and was a useful entry into the field.
- Familiarity: it allowed researchers to identify and map organisational practices and routines over time and from different staff and patient perspectives.
- Project Promotion: it gave the research an ongoing and human profile within busy clinical areas.
- The 'Taken for Granted': it allowed researchers to identify routine and practices that staff or patients might not notice or question as unusual to them during interview.
- The 'Unspoken': it allowed researchers to identify those dimensions of work life and patient care experiences and behaviours that are not consciously recognised by interviewees.

In addition, staff shadowing focused on:

- Real-time observation of which factors shape patient experiences of staff; of staff and patient interactions; staff and staff interactions and communication patterns and of staff and patients' reflections on these interactions.
- The opportunistic follow-up of staff and patient stories and experiences of clinical work and patient care through interview.

This observation work involved staff shadowing, following one or two members of staff in their routine work activities and through the course of a work shift. Observation was led by two of the research team with clinical backgrounds (JM and MA) with support from GR and these focused on staff's formal and informal interactions with patients, carers, immediate and other colleagues as well as their expressed feeling about this. Observation was undertaken for whole or half shifts during which one researcher shadowed various staff members (registered nurses, medical staff, nursing assistants and student nurses) for varying periods of time- 30 minutes – 5 hours, median 2-3 hours. The observation work also included organisational loitering, when the wider and often rapidly changing work environments and contexts of patient care and staff wellbeing could be explored. For example, the researchers also sat with patients and carers observing care for a group of patients in acute care areas; sat in on staff breaks; on ward/ team handovers and in team meetings. Field notes were written up or dictated on the day of the observation by each researcher; transcribed verbatim and made available to the research team as word text for qualitative analysis as soon as possible.

Cross-site contrast and comparison of observational research data was important to reduce the tendency of researcher bias as well as to meet the objectives of the research project. Ongoing comparative analysis of observation data across the microsystems was ensured in two ways. First, regular project team meetings continued through the fieldwork period so that 'debriefing' provided opportunity for extensive discussion of comparative findings. Second, the project research team worked as 'lead' and 'second' researchers across each of the clinical microsystems so that

emergent data could be discussed and compared between researchers; between clinical microsystems and between case study organisations.

4.4.4 Staff wellbeing survey

As part of the study we conducted two repeat surveys of staff in the eight microsystems. Following initial piloting of the survey questionnaire with a small number of staff in two of the microsystems, the first full staff wellbeing survey was carried out in April-June 2010 (time 1) and the second in September-October 2010 (time 2). The data from the two surveys were used to test the overall model underpinning the quantitative part of the research presented in Chapter 2 (see Figure 3).

Procedures and sample

On both occasions of measurement, staff questionnaires were put into survey packs comprising a letter introducing the project and inviting the staff member to participate in the research by completing the survey and returning in the pre-paid envelope to the research team. Those returning the completed survey were invited to take part in a prize draw¹ as an incentive to completion. The research team obtained staff lists from ward managers and medical consultants and we either hand-delivered the packs to the relevant staff mailboxes or pigeon holes; gave them directly to staff members or mailed them by post. We sent a reminder pack 2-4 weeks after the first mail out and put up posters in staff rooms to remind staff that the survey was taking place. Additional attempts to recruit the total staff population in each microsystem included for example, introducing the project, survey and invitation for interview through 'survey monkey' (for junior medical staff without access to 'pigeon-holes'). We then repeated the process again at time 2 (after 3-4 months) for those who had returned questionnaires at time one, including reminders after 2-4 weeks.

At time 1, 319 of the 742 questionnaires that were distributed were completed and returned, for an overall response rate of 43 per cent. At time 2, 126 of the 301 respondents who participated in the time 1 survey and who were then contacted at time 2 returned completed questionnaires, for an overall retention rate of 42 per cent. Although relatively high by the standards of longitudinal research, the retention rate varied considerably across the eight sites. Time 1 and time 2 response rates across the microsystems are shown in Tables 8 and 9 below.

¹ Staff participants in each microsystem had the opportunity to win one of two £75 shopping vouchers.

Table 8. Staff survey responses and rates by clinical microsystem: time 1

<i>Case study site</i>	<i>Sent</i>	<i>Returned</i>	<i>Completed</i>	<i>Used in analysis²</i>
1.1 EAU/ short stay	119	47 (39.5%)	46 (38.7%)	45 (37.8%)
1.2 Maternity	134	82 (61.2%)	79 (59%)	79 (59%)
2.1. Medicine for the Elderly	192	79 (41.1%)	71 (37%)	66 (34.4%)
2.2. Haemato-oncology	77	19 (24.7%)	18 (23.4%)	16 (20.1%)
3.1. Adult Community and Palliative Home Care Nursing Service	125	30 (24%)	30 (24%)	29 (23.2%)
3.2. Community Matron Service	14	11 (78.6%)	9 (64.3%)	8 (57.1%)
4.1. Adult Community and Palliative Home Care Nursing Service	32	30 (94%)	29 (90.1%)	27 (84.3%)
4.2. Rapid Response/Intermediate Care Service	49	31 (63.3%)	31 (63.3%)	31 (63.3%)
TOTAL	742	329 (44.4%)	319 (43%)	301 (40.6%)

Table 9. Staff survey responses and rates by clinical microsystem: time 2

<i>Case study site</i>	<i>Sample at time 1 re-surveyed</i>	<i>Sample at time 2 and retention rate</i>
1.1 EAU/ short stay	45	9 (20%)
1.2 Maternity	79	53 (67%)
2.1. Medicine for the Elderly	66	23 (35%)
2.2 Haemato-oncology	16	10 (63%)
3.1 Adult Community and Palliative Home Care Nursing Service	8	6 (75%)
3.2 Community Matron Service	29	0 ³ (0%)
4.1 Adult Community and Palliative Home Care Nursing Service	27	14 (52%)
4.2 Rapid Response/Intermediate Care Service	31	11 (35%)
TOTAL	301	126 (42%)

² As the survey was designed for staff giving direct care to patients we excluded administrative staff, for example ward clerks, community administrators in our final analysis.

³ It was not possible to re-send these questionnaires at time 2 in microsystem 5, as due to access delays there was not sufficient time to allow a 3 month gap between time 1 and time 2 before data collection ceased.

The overall research model presented in Chapter 2 (Figure 3) was tested using the panel sample. In other words, the main quantitative analysis presented in later chapters and designed to test our overall research model is based on the responses of the 126 employees who participated in both surveys and for whom data were available on all study variables on both occasions of measurement.

Measures

The staff wellbeing survey was developed after a full review of the literature and an examination of potential tools (see Appendix 11). The questionnaire was explicitly designed to measure all the main variables in our research model (see Figure 3, Chapter 2), as well as a number of demographic characteristics of respondents. The specific items and measures included covered climate (organisation, local/work-group), wellbeing (job satisfaction, positive and negative affect, emotional exhaustion), individual differences (affective patient orientation, work dedication, job skills), job demands and resources (job demands, job control, job clarity, positive organisation support, supervisor support, co-worker support) and perceived job performance (relational performance, functional performance, in-role performance, discretionary performance, overall performance, helping behaviour, continuous improvement).

Two additional measures were included: the 12-item General Health Questionnaire (GHQ12) and a 'job stress' scale comprising 3 items. The GHQ12 is an abbreviated version of the longer 60-item GHQ scale which was designed for use in population surveys and primary care settings. Its original purpose was as a screening instrument for psychiatric illness and focuses on recent experience of, and intensification, of symptoms (318). For example has the individual lost much sleep over worry during the last four weeks to which they can respond: not at all, no more than usual, rather more than usual or much more than usual.

All variables in our model, except for the patient care performance variables, were measured using existing validated scales. In a few instances the scales were slightly adapted to fit the research context and the requirements of the study. The patient care measures were developed explicitly for this study in order to capture the important distinctions between in-role functional and relational performance, and discretionary helping and continuous improvement behaviours discussed in Chapter 2. The source and internal reliability of all the main measures covered in our research model and used in the subsequent quantitative analysis are shown in Table 10 below. As can be seen, all measures showed adequate internal reliability. Full details of all measures are provided in Appendix 11, including a detailed discussion and analysis of the construction of the four patient care performance measures.

Table 10. Summary of measures used to test research model

Measure	Number of items	Source	Internal reliability
Relational performance	8 items	New scale	0.91 (T2)
Functional performance	4 items	New scale	0.85 (T2)
Helping behaviour	5 items	Adapted from Peccei & Rosenthal (49)	0.79 (T2)
Continuous improvement	3 items	Adapted from Peccei & Rosenthal (49)	0.62 (T2)
Org. Patient care climate	6 items	Adapted from Schneider et al. (237)	0.78 (T1)
Local patient care climate	3 items	Adapted from Peccei & Rosenthal (49)	0.79 (T1)
Job satisfaction	1 item	Warr (250)	n.a.
Positive affect	6 items	Warr (250)	0.87 (T1)
Negative affect	6 items	Warr (250)	0.88 (T1)
Emotional exhaustion	8 items	Maslach et al. (25)	0.92 (T1)
Affective patient orientation	3 items	Adapted from Peccei & Rosenthal (44)	0.68 (T1)
Work dedication	4 items	Schaufeli et al. (319)	0.86 (T1)
Skills and competence	3 items	Adapted from Peccei & Rosenthal (49)	0.81 (T1)
Job demands	4 items	Adapted from Caplan et al. (290)	0.76 (T1)
Job control	4 items	Adapted from Wall et al. (320)	0.83 (T1)
Perceived org. support	8 items	Eisenberger et al. (291)	0.89 (T1)
Supervisor support	5 items	NHS survey	0.91 (T1)
Co-worker support	3 items	Price et al. (321)	0.73 (T1)
Job clarity	4 items	Price et al. (321)	0.81 (T1)

Descriptive statistics for all the main variables in the model are reported in Appendix 12.

Staff survey analysis procedures

The research model was tested with the two-wave panel data using *Mplus* 5 (292) using multiple regression analysis with maximum likelihood

estimation with robust standard errors. However, the hierarchical nature of our data, with individuals nested in the different sites, raises the possibility of the non-independence of observations within sites (see Table 30 in Appendix 13 for a more detailed analysis of this point). To take account of this non-independence in the data we used the complex analysis option in *Mplus* (292) using site as the clustering or grouping variable.

When testing for relationships using two-wave panel data, the standard approach is to regress the dependent variable at time 2 on the independent variables at time 1, controlling for the dependent variable at time 1 (293). This approach is appropriate when a reasonable amount of change has taken place in the dependent variable between the two occasions of measurement. In our study, the time interval between the two surveys was quite brief, thereby limiting the likelihood of significant change in the dependent variables between the two occasions of measurement. This is confirmed by the results shown in Appendix 13 (Table 30, columns 2 – 5) which indicate considerable stability over time in the model variables. When testing our hypotheses, therefore, we did not control for the relevant dependent variable at time 1. Instead, we simply regressed each of the dependent variables at time 2 separately on the set of antecedent variables at time 1.

It is important to note that although we do not control for the dependent variable at time 1 in our analysis, using the longitudinal data and regressing the dependent variables at time 2 on the antecedents at time 1 allows for a more systematic test of temporal effects than would be possible if only cross-sectional data were used. Moreover, using a two-wave design provides for the partial removal of method variance associated with a single collection of self-report data (294-296), thereby helping to minimise problems of common method bias in the analysis.

Finally, before testing our hypotheses, we checked the representativeness of the panel sample compared to the main sample of employees who took part in the time 1 survey. The results of this analysis are reported in Appendix 13.

4.4.5 Patient experience survey

As outlined in Chapter 2 the literature on patient experience makes distinctions between 'functional' or 'transactional' and 'relational' aspects of care. We were keen to measure this in our patient experience survey which was developed with this distinction in mind. We also wanted to capture information on staff behaviours (that may link to staff wellbeing) as experienced by patients (mood, tone of voice etc.). Following review of a number of patient experience measures and tools from the UK and elsewhere -e.g. Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool from the USA, Picker tools in the UK and Patient Evaluation of Emotional Care During Hospitalisation (PEECH) tool from Australia, we selected the following scales for our survey too: (1) Patient Evaluation of Emotional Care During Hospitalisation (PEECH) tool (322) to measure the relational aspects of care and (2) the Picker short-form instrument (PPE-15)

(323) and (3) a selection of additional Picker items highly relevant to patients and which related to the aims of the study. The Picker items measure the functional or transactional aspects of care. The Picker Institute developed the Picker Patient Experience questionnaire to measure quality of care in reaction to criticisms of other instruments that lacked a conceptual basis. At the heart of the instrument are 15 core questions known as PPE-15. These fifteen items, which were derived from the longer form Picker in-patient survey were found to provide a picture of in-patient experiences of health care when tested in five countries, providing a core set of questions which allow meaningful comparisons (323). These 15 questions can be used to produce a count of 'problems'. Our analysis uses this index and twelve additional Picker questions that gauge patient experience in relation to: courtesy, respect and dignity; confidence and trust; nurse staffing levels; involvement in care; help with meals; how well doctors and nurses work together; wanting to complain; rating of care received; willingness to recommend the service to family and friends. Thus the survey comprised 21 of the 23 items from the PEECH tool⁴, 15 items from the Picker shortened tool plus twelve other Picker items making 48 items in total (see Appendix 14) and seven questions about the patient (gender, year of birth, ethnicity, ward (acute microsystems)/how long you have been receiving care (community microsystems), rating of health, long-standing conditions and if any what difficulties do these have on every day living.

PEECH was developed for acute care settings. This instrument has four components or subscales; levels of security, knowing, personal value and connection. The first three components were identified during previous work aimed at understanding how interpersonal interactions influence patients' experience of emotional comfort (322). Displaying competence, developing relationships and indicating availability all help to make a patient feel secure. Keeping patients informed helps raise their perceived level of knowing and non-verbal and verbal interactions help to enhance a patients feeling of personal value. Psychometric analysis revealed a fourth factor that was named level of connection which contained items previously assigned to level of security that were all about meaningful relationships between staff and patients. Questions in the PEECH tool helped capture patient experiences of staff attitudes and behaviour e.g. staff used appropriate eye contact, tone of voice, displayed gentleness and concern.

There are sufficient similarities between the Australian and UK healthcare systems for us to be confident that this instrument would be valid and robust in UK healthcare settings. We have taken the opportunity to subject the instrument to further psychometric testing (see Appendix 20). That testing suggests that we should continue to use the instrument in its current form. Williams recently tested the instrument on a second sample in an acute setting (personal communication) and confirmed the internal structure found previously (322). Level of connection was scored lower by

⁴ We omitted one item from the original PEECH tool, as we were administering to patients after they had left hospital and not whilst still in-patients. This question: '*I had previously met the nursing staff that I have seen during the past 24 hours*' was omitted.

patients than the other three components in William’s most recent study (Williams, personal communication, 2011). We have made the assumption that following adaption of some of the wording PEECH remains a valid instrument for community settings.

Each survey was made into a colour coded booklet with a front cover unique to the relevant microsystem, in some cases describing the staff we wanted patients to base their answers on, including their type of uniform (as some patients in community settings may see many staff form a variety of services). Like the staff survey there was also an opportunity to opt in to an interview with a member of the research team (see questionnaire in Appendix 14). Patient questionnaires were put into survey packs comprising a letter of introduction inviting the patient to participate in the research by completing the survey and returning in the pre-paid envelope to the research team. The research team were supported by ward managers, administrative and clerical staff who drew up names of patients or spoke with patients first to see if they would be willing to participate, or mailed the packs by post directly to patients as per data protection act. Table 11 details the response rates by microsystem. Not surprisingly those offering acute services had the largest number of responders.

Table 11. Patient survey total returns by clinical microsystem

Case Study site	Sent	Returned	Completed
1.1 EAU/ short stay	690	228 (33%)	159 (23%)
1.2 Maternity	580	297 (51%)	139 (24%)
2.1. Elderly medicine	111	38 (34%)	26 (23%)
2.2 Haemato-oncology	245	114 (47%)	101 (41%)
3.1 Adult Community Nursing Service	29	24 (82%)	10 (27%)
3.2 Community Matron Service	37	18 (49%)	16 (84%)
4.1 Adult Community and Palliative Home Care Nursing Service	57	36 (63%)	34 (60%)
4.2 Rapid Response/Intermediate Care Service	40	19 (48%)	13 (33%)
TOTAL	1779	774 (44%)	498 (28%)

Patient survey analysis procedures

Summary statistics (Means, Standard Deviations) were calculated for each microsystem and differences between microsystems was tested statistically using analysis of variance. Given that sites were purposively selected to be different we would expect to find significant variation across the different measures. This was the case for most variables unless otherwise indicated. In figures the microsystem means are presented without standard error bars to avoid overcomplicating the graph and to help identify key trends

and to compare with findings emerging from impressions gained in 'the field'. Both Picker and PEECH microsystem means were plotted alongside each other to ascertain whether these two instruments were tapping into different or similar aspects of patient experience. On most occasions they tracked each other quite closely. For presentation purposes some of the measures have been standardised to a 5-point scale: PPE-15 (0-15 count of problems), PEECH (0=none, 1=some staff, 2=most staff, 3=all staff), Picker (scale 1-4) and made directionally the same so for example the scoring for negative effect, job demands and emotional exhaustion were reversed. Three community microsystems had less than 20 patients responding (Table 11), therefore statistics for these microsystems should be treated with a degree of caution.

Analysis of comparisons between patient reported experience and staff reported experience for patient and staff surveys

The small number of microsystems placed limits on what could be performed statistically in terms of comparisons between patient experience and staffing variables– for example multilevel modelling was considered but the small number of purposively, rather than randomly selected, microsystems meant this was not pursued. We did however compare patient and staff survey results for each of the microsystems with descriptive statistical methods. Summary statistics (Means, Standard Deviations) were calculated for overall PEECH and Picker scores from the patient survey and for various factors in the staff survey in each microsystem and differences between microsystems was tested statistically using analysis of variance.

4.4.6 Semi-structured interviews staff and patient interviews

Open-ended interviews were undertaken with patients and staff within each of the microsystems to explore issues of meaning and process as well as to identify direct and indirect factors shaping staff wellbeing and patient experience that were not illuminated through quantitative methodologies. An interpretive research paradigm was employed as the underlying approach which seeks to understand 'the study of meanings that social actors attach to their actions... and is also more interested in understanding subjective experience that 'objective' data' (303) [p466]. As Lee (324) notes, interpretive methods are indicated when the research task is description, interpretation and explanation of a phenomena rather than the estimation of its prevalence.

Staff interviews

Semi-structured interviews with staff were undertaken to explore staffs' views and experiences of:

- the nature and necessary conditions (facilitators and inhibitors) of good patient experience
- the relationship between work wellbeing and the work environment (including organisational arrangements, culture or climate)

- the relationship between (their own and others') work wellbeing and patient experience
- the significance of emotions at work, emotional labour and customer orientated care.

A number of strategies re staff interview sampling in each microsystem were pursued. Initially all staff in each microsystem were invited to participate through an opt-in process at the end of the staff wellbeing survey. In community health services, where these organisational systems were less well developed or in flux, staff were contacted using service administrator and service manager staff lists. One month after surveys had gone out a range of additional staff recruitment strategies were employed which included introducing the project to staff in the course of field observation work.

Staff who agreed to be interviewed signed formal consent forms and were given the opportunity to read the information sheets and ask questions of the research team. Interviews were undertaken independently by two researchers from the research team (GR and JM in Oakfield and Elmwick and MA in Ashcroft and MA and JM in Larchmere). Each interview was conducted on a one-to-one basis and designed to be open-ended or conversational in style. We used a topic guide (Appendix 16) that was designed to probe ideas on patient experience and staff wellbeing and on the interconnections between the two.

Interviews lasted between 45 minutes and 75 minutes. Particularly for night staff, part time staff and staff who left the service, telephone interviewing was used. Each interview was audio-taped, anonymised and transcribed as a word document as soon as possible after data collection.

Staff interviews were conducted in privacy and on a one-to-one basis and always with a researcher already familiar (through field observation) with the interviewee's place of work.

Patient interviews

The rationale for the patient semi-structured interviews was to explore patients' views and experiences of:

- what makes good patient care (including key 'touch points' of patient experience)
- what factors facilitate or inhibit good patient care
- the significance of staff behaviours and of patients' relationships with staff to the experience of patient care
- the significance of staff wellbeing to patient experiences of care.

This rationale underpinned the development of the topics and questions in the patient interview schedule (Appendix 17), focusing particularly patients' experiences of emotional care by staff (322) and also briefly exploring the ongoing attention of the service to patients' views and experiences of emotional care.

Accessing and sampling of patients from within each microsystem involved a range of strategies adjusted to organisation and service structures as well as patient demographics. In the acute hospital trusts patients were initially asked to opt into an interview through the survey. In some areas of acute services patient response rates were low, as in services for the elderly. In this microsystem access strategies for patient interviews were adjusted. Thus patients or relatives were approached by a researcher in person who introduced the research project and invited them for interview as they were leaving the service. Additionally, in this microsystem, field observation time was increased to make up for lower patient interview recruitment.

In community health services accessing patients for the patient survey and interview research relied on self-elected front-line staff to act as 'gatekeepers' to individual patients. Additionally, the majority of patients in community services were frail or elderly and survey response in this population was anticipated to be low. The patient recruitment strategy in these services was for patients to be approached by a researcher in person during field observation and revisited at a time suitable to them, where a researcher undertook survey completion with patients within the context of an interview.

Patients who agreed to be interviewed signed formal consent forms and were given the opportunity to read the information sheets and ask questions of the research team. Interviews with patients were undertaken in patient's homes for the most part, with some telephone interviews if this was preferred or more convenient for patients. Patient interviews lasted between 20 minutes and 50 minutes, depending on patients' health and degree of interest, and were conducted on either a one to one basis or, if a patient preferred, with an accompanying relative. They were conducted in English and one interview was conducted through a sign language interpreter. As with staff interviews, the patient interviews were audio recorded and as soon as possible after interview the recording was coded and sent for transcription to a word document.

Analysis of staff and patient interview data and fieldnotes

Qualitative data collection and analysis followed a 'funnel' structure, characteristic of ethnographic study (325). The analytical approach was directed towards the progressive focusing on our stated research aims as well as the theoretical sampling of the metanarratives within our case studies that would most clearly illustrate and contextualise both general and particular themes (326)(p 390). For our qualitative data analysis these research aims were summarised as:

- Identification and analysis of attitudes and behaviours of staff described by patients as shaping their experiences that may connect with, and be influenced by, staff wellbeing (Aim 1).
- Identification and analysis of which particular staff attitudes, affect and behaviours impact on patients' experiences of care (Aim 2).
- Description and analysis of staff experience at work that might affect staffs' capacity to give high quality patient care (Aim 3).

- Analysis of the key organisational factors that influence patient experience and staff wellbeing (Aim 4).
- Identification and examination of the issues of 'emotion at work', emotional labour and customer orientated care in relation to the above (Aim 5).

Following Rapley [p274] (327), case study data organisation, coding and analysis involved an ongoing and iterative six-stage process that was both inductive and deductive in relation to the aims stated above. Across the eight case studies the six stages were:

1. Inductive initial open coding of all interview transcripts and observational fieldnotes was undertaken through reading and re-reading and making notes / creating theme files and category sections in Microsoft word documents. For example, codes relating to staff wellbeing in the Emergency Admissions Unit included feelings of detachment, the pace/intensity of the work, staff motivation and morale, whilst codes relating to patient experience included power relations, the 'undeserving patient', and patient expectations.
2. Deductive analysis within and across case study data was driven by the specific aims and objectives of the study; we examined the data for issues associated for example with 'emotion at work', emotional labour and which particular staff attitudes, affect and behaviours impact on patients' experiences of care.

The research team met to review and discuss these emergent codes which together with quotations where appropriate, were then mapped onto tables (Figure 5) constructed for each of the eight case studies to highlight how each code was situated both in terms of four experiences relating to aims (patient experience and staff wellbeing from both patient and staff perspectives) and at one or more of the following levels of the health care system: external context, health care organisation, team and individual. Figure 5 illustrates some themes emergent from data organisation that were used for the case study analysis of one adult community nursing service.

Figure 5. Example of emergent themes from Adult Community Nursing Service

	Patient Experience (pt. perspective)	Patient Experience (staff perspective)	Staff Wellbeing (pt. perspective)	Staff Wellbeing (staff perspective)
<p>(Macro & MESO) External and organisation Context</p> <p>Emergent Theme Example:</p> <p><i>Introduction of Electronic Patient Record System/'Paper work'</i></p>	<p>2 patients identify differences between staff behaviours ('time for them' or 'irritable') caused by amount of paperwork more senior nurse has to do.</p>	<p>Less thorough clinical knowledge of patient on record</p> <p>Less time to spend with patients</p> <p>Increased risk of clinical error due to lost information (notably for nurse prescribers) (602)</p>	<p>2/16 patients note that staff seem to keep a lot of notes but still care for them differently and ask them questions about their care</p>	<p>Stressful (system in development; new skill; lost/forgotten clinical information cannot record accurately) (all staff some issue re EPS)</p> <p>Stressful - Time consuming: pt assessment can take 3hrs to complete (602) 'Worry': risks of litigation 612/14/06) recording needs unclear (601;606).</p> <p>Demotivating (time taken from 'real work' of patient care) (601;607;609)</p>
<p>(MICRO) INDIVIDUAL</p> <p>Emergent Theme Example:</p> <p><i>Emotional Work</i></p>	<p>'Take work home' when dealing with deaths at night (few staff involved and lonely time) (609)</p> <p>Growing attached to/listening to patients, 'go in [patient's home] cheerful and come our exhausted' (609)</p>	<p>Patients prefer to die at home with people and nurses they know</p> <p>Good for patients to talk because some 'don't have anyone else'</p>	<p>'Staff who are friends' noted by majority of longstanding patients/carers.</p>	<p>Patients aren't easy</p> <p>People 'let fly' when ill</p>
<p>(MICRO) TEAM</p> <p>Emergent Theme Staff/Patient Relationships Example</p> <p><i>Visiting known patients/families (not necessarily the 'easiest' patients) (all staff)</i></p>	<p>Enjoy 'chatting', 'cheering someone up', 'having a laugh' (all)</p> <p>Visiting patients you know is relief from office/team pressures (613)</p> <p><i>F/notes 1.3.10: 'knowing a patient' is clinical, social and personal history, daily</i></p>	<p>All patients will value this (all staff)</p> <p><i>FNs: 11.2.09 For ('known' 'special') patients to be able to manage staff adapt</i></p>	<p>Don't like 'different faces every day' (9/10 patients).</p> <p><i>FN (4): older patients often confuse staff (many staff ignore this); patients visited by staff they know better are v. different (talk, inquire, confide)</i></p> <p><i>FN: 11.2.09 In domiciliary setting patients sometimes</i></p>	

	<i>routines, expressions (pain), sense of humour, rhythm of clinical intervention</i> <i>F/notes 1.3.10: co-ordination (advice, calls) of service 'flows' from this knowledge (not separate job)</i>	<i>norms and routines eg. smoking; lifting; fetching (extra things highly personalised)</i>	<i>unaware of norm/of what is 'extra' or compromise unless staff remind them (which these staff don't); other times offer gifts to team.</i>	
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As Figure 5 illustrates we used a multi-level framework to determine how the macro (wider context including societal factors and national healthcare system policies), meso (organisational) and micro (clinical team and individual staff) (311, 312, 328) separately and in interaction with each other impact upon staff wellbeing and patient experience (see Appendix 18 for fuller example). We reflected upon these interactions and dynamics when formulating our conclusions at the end of this report (Chapter 10).

3. Subsequent focused coding included the identification of exception events, the search for negative evidence or cases (325). In tandem we cross-checked the qualitative analysis with the staff and patient survey data results for each case study.
4. Within, and across, the eight case-study sites, we then conducted a further analysis of the mapped codes in order to identify and refine key 'in case' and 'across case' issues. This allowed gradual refinement of codes and themes underpinning the links between patient experience and staff wellbeing affect and behaviours.
5. Finally through the process of undertaking steps 1-5 above and through ongoing discussion amongst the research team to develop and refine emergent themes, we were able to select meta-narratives for highlighting in our microsystem case studies (Chapter 9 and Appendix 24).

Our data analysis, within and across case-study sites, involved three researchers (JM, GR and MA) who jointly agreed on the focused data codes and the development of key analytic themes both across and within the case studies (see above). This means of triangulation by analytical validation was conducted to 'discover if inferences are likely to be valid.' (325)[p 184].

4.5 Summary

This chapter has outlined the two phases of the research process, the multiple sources of data that were collected and how these link to the stated objectives of the study. In Phase I we held two focus groups of patients with recent experience of healthcare and a range of health conditions and sought their views on the links between patient experience and staff wellbeing. In this phase we also negotiated access to four NHS trusts; two in the acute and two in the community sector. In each of these

we interviewed 13-14 senior managers in order to understand their views of staff wellbeing and patient experience and to determine any interventions underway in their organisations that were seeking to improve either or both. In phase two we selected two microsystems in each of the four case study trusts, (total eight) to reflect different types of care relationships and settings and different patient and staff groups. In each microsystem we undertook a staff and patient survey, staff and patient interviews and non-participant observation of routine day-to-day interactions and of team and care processes. In this chapter we have detailed each of these data collection techniques, tools and analysis with further details in the appendices to this report. Our next chapter presents the study results.

5 Results: Phase I fieldwork; patient focus groups and manager interviews

The following section reports our findings from Phase I of the study.

5.1 Focus group findings: Phase I

Remembering the bad and good

Most focus group participants recalled lived and vivid examples that indicated, for them, the relationship between patient experience and staff behaviours or staff wellbeing. These examples, some recalled several years after the event, often summarised the contributors' overall view of a health service or care setting. It was clear that patients' or relatives' experiences of care (and particularly of care staff) were affected as much by direct observation of others' care as by their own care experiences.

The examples discussed centred on the quality of relational care given, particularly by direct care nursing staff. Examples of good relational care (including doctors taking time to explain events clearly; nurses recognising anxiety on a face and acknowledging this; night staff responding to a frightened or confused patient) were also noted (often from the same hospital unit, ward or shift when poor care was experienced).

Reflecting on the reasons for poor care behaviours

For some participants a view of front-line staff as either good (because they were vocational) or bad (because nursing was 'only a job') persisted. Other participants perceived there to be a third type of staff: those who had become disillusioned over time. This third category allowed the focus groups to develop a more nuanced view of the antecedents of staff wellbeing and care behaviours.

The groups felt that the care of particular patients and in particular services (notably Emergency Admissions Units) exhausted nurses and left them feeling stressed and even aggressive towards some patients. Several participants noted the physical demands of 'heavy' ward with elderly patients needing basic care.

Participants sustained a view of all nursing work as meeting immediate, rather than longer term, care needs and the lack of visibility of staff in ward areas or bed areas was often equated to a lack of nursing staff. In addition, however, some participants noted the importance of good management of direct care staff and the inequities, for staff and patients, when this management was poor. The leadership skills and approaches of ward sisters were noted as especially important to patient care and staff experience.

The influence of ward atmosphere and the built environment on both staff behaviours and patient wellbeing was discussed in one focus group. These

included obvious influences (physical overcrowding or excessive noise) and less clear influences on patient care (were the dying nursed on general wards because nurses lacked the insight to move them or because the ward lacked side rooms?). Participants also identified the changing atmospheres on wards (that affected staff and patients) across different work shifts and, particularly between day and night shifts.

While all participants agreed that it was easy to identify a good nurse and staff with a caring attitude, they felt that the behaviours of some staff (particularly those from other cultural backgrounds) might be misunderstood by patients as uncaring.

Balances of power

Participants noted the limited capacity of patients and relatives' to directly challenge staff who gave poor care to patients (they felt they risked being penalised and being neglected by these staff).

5.1.1 Summary

Patients' experience of their own, and others', direct care is vivid and can define an overall and very long term impression of an organisation, service or service area for years to come. Nevertheless, patients clearly discriminated between good and bad individual staff within services, wards or shifts. This discrimination rested on the nature of relational care received. The focus groups distinguished between direct care work as a job and as a vocation (and insisted on the importance of the latter). At the same time, however, experienced patients recognised the influence of the workplace – notably, work in particular 'heavy' or dangerous service areas, in poor built environments and in poorly managed wards - on staff behaviours towards patients. The focus groups recognised that patients might misunderstand the behaviours of staff from different cultural backgrounds. However, overall the focus groups emphasised the limited capacity of patients and relatives to directly question staff about poor care and poor caring behaviours.

5.2 Senior manager interviews: Phase I

Following the patient council focus groups with patients we accessed our four study sites and continued Phase I empirical data collection. In each site we began with interviews with senior managers as outlined in Chapter 4.

As outlined in Chapter 4 the four organisations which became our study sites were purposively selected (based on nationally available routine data) to provide a 'high' and 'low' performing organisations with regard to staff wellbeing and patient experience in both the acute and community care sector (see Tables 3-5 in Chapter 4 and Table 12 below for further details). The four organisational case study sites comprised two large acute trusts (called in this report Oakfield and Elmwick) and two community provider services (called Ashcroft and Larchmere). Both acute trusts - Oakfield and Elmwick - were located in central England. Elmwick was a foundation trust but Oakfield was not. Elmwick serves a city with a rural

hinterland from a single site whilst Oakfield was much more rural with multiple hospital sites located significant distances apart. Ashcroft and Larchmere, the two community provider services, were located in the north and south of England respectively; they served contrasting demographic populations. National patient and staff survey results and initial discussions with senior managers in each of the organisations indicated that these case study sites had contrasting levels of patient experience and staff wellbeing.

Table 12. Four study sites

Type of trust	'Low performing'	'High performing'
ACUTE	Oakfield	Elmwick
COMMUNITY	Ashcroft	Larchmere

5.2.1 Organisational context: Oakfield Acute Trust

A large multi-site Trust in a rural location with a history of financial problems

Oakfield is one of the largest NHS acute Trusts in England employing 7,800 staff and volunteers and providing over 100 clinical services to a local population of 718,000 people. The Trust has 1,462 beds and responds to approximately 755,000 patient attendances a year. The Trust total income in 2007/08 was £344 million, approximately £217 million of which was spent on salaries and wages. Services are delivered at eight hospitals and more than 20 other locations (including GP premises and community facilities). The vast majority of services are provided at four main hospital sites which are geographically dispersed and were once - previous to a series of mergers in the last 10 years - all entirely separate organisations. The Trust was reported to have a relatively low level of turnover in nursing staff given its geographical (and predominantly rural) location but as the Chief Executive put it this had its disadvantages too:

"It's like an island ... if you're in London, you have 30% turnover of nursing, here we have about 6%. So, you know, there's a lot of blending of ideas [in London Trusts], there's a lot of blending of thinking, there's different way of doing things, you know, staff get to pick up good and bad ways all the time. That's not happened here. People work on the same practices that they work day in and day out for many years, and change, as a consequence, is quite slow".

Oakfield is a relatively poorly performing non-Foundation Trust with historical financial deficits and - at the beginning of our fieldwork - was facing further financial cuts over the next five years. Minutes of the Trust Board meeting held in June 2009 stated that reductions in NHS funding nationally over the next five years meant an expenditure reduction of £15m per annum for the Trust (approximately 5% of 2007/08 income); £75m

over five years. The Chief Executive was reported as saying that this would be achieved by changes at 'at a system level ... at an organisational level, [and] ... the performance team/practitioner level.' The Chief Executive continued to say that leadership through the process would be challenging, and that the Trust would need to provide assurance to patients and staff that the process was being successfully managed. The Trust had begun a programme of work exploring a range of short and medium term cost saving options, whilst improving efficiency and quality and where possible avoiding compulsory redundancies.

The Chief Executive summarised the state of the organisation in 2008:

"You had got a completely demoralised and demotivated staff because, although you can't prove it, you could probably assume it quite confidently because you've got no stability, you've got a constant worry about job security because you know you've got a massive turnaround programme that is going to try and save tens of millions of pounds. No one knows it because there's poor communication. So you've just got fear and questions going round. So, you know, people were sacked because they're manipulating the waiting list, you've got Healthcare Commission who, who have been in and done a study and said, 'There's bullying and harassment throughout the organisation,' you've got no approach to health and safety. You know, you've got all these starting positions." [CE]

Significantly, there had been a recent restructuring of the whole organisation into clinical directorates each with a clinical director with management responsibility; the sense was that this new structure was still 'bedding in' at the time of our Phase I fieldwork:

"[This CE is] the first one that's come in and made that feel more real to people about their own personal accountability. But it's still taking a very, very long time to get. And I think our structure is still, at the moment, that people's roles aren't entirely clear in terms of who's accountable for that and that is creating some issues for people as well." [Dir Nurs]

'Work stress' - Health & Safety Executive serve an Improvement Notice

Oakfield has scored consistently higher than the national staff survey average for reported levels of 'work stress' and consistently lower for staff job satisfaction. In October 2008 the Trust was served an Improvement notice by Health & Safety Executive (HSE) for 'failure to make suitable and sufficient assessments of the risks to the health and safety of the Trusts employees from exposure to Work Related Stressors for the purpose of identifying and implementing any preventative and protective measures' (source: Executive Board meeting paper, April 2009).

In November-December 2008 the Trust commissioned an external consultancy to carry out a major 'Staff Work and Wellbeing' survey which incorporated the Health & Safety Executive Stress Risk Assessment Survey - and which became known locally as the 'Stress Survey'; "probably the biggest intervention in terms of wellbeing that we're involved in at the moment" (Dir HR). A 'Management of Stress Working Group' was duly

established, chaired by the Director of HR (and including the Deputy Chief Nurse for Governance & Risk), to “oversee the implementation of the survey, and to develop an action plan to build on the results ... there was a policy and procedural change that we need to implement” [Dir HR]. The survey - comprising 14 profile questions and 35 Stress indicator questions - was completed by 1,841 staff. The final report stated that:

‘When reviewing the organisation as a whole, the results for the survey were generally below average when compared to similar organisations and this is also reflected in the HSE Management Standards where the results for six on the HSE categories showed a clear need for improvement ... A third of staff who completed the survey added some text comment in relation to their workplace ... This is a higher proportion than we would normally see in this type of organisation.’

The report went on to state that ‘there are some general stress problems affecting the organisation with specific ‘hot spots’ where the risk of stress appears notably higher.’ The Working Group would then “work with the management teams in these areas and facilitate some focus groups because we’ve got raw data and we’ve got lots of data, we have lots of quantitative and qualitative data, but we need to understand exactly what it means on the ground” [Dir HR]. One of these three hotspots was the emergency directorate, part of which - the Emergency Admissions Unit (EAU) - is one of our Phase II clinical microsystems.

An increasing focus on patient experience at senior levels

‘Measuring patient experience’ is a key role of the Patient and Public Involvement (PPI) Manager who cited complaints that come through PALS and comments on the NHS Choices website as regular sources that keep the Trust informed of issues impacting on patient experience. The Director of Nursing was credited with having brought a new focus to improving patient experiences:

“[Director of Nursing] is inspirational in terms of patient experience, patient outcomes, safety. Second to none in my experience in the NHS. There seems to be an endless innovative approach to improving patient experience and outcomes and that’s really fantastic. I’m a bit in awe of how they come out and they become embedded in the organisation and that comes from everything from infection control, through to adverse incidents to the Patient Experience Trackers, the Learning the Lessons Group. Probably the most comprehensive and impressive structure, policies, strategies, initiatives, really leading the way, I feel, in improving patient outcomes and patient experience”. [Dir Estates & Facilities]

The arrival of the Chief Executive who was in post at the time of our Phase I fieldwork led to an increased emphasis on delivering customer services training to the staff:

“I suppose the big change is this whole change around customer focus. And that, I think it must be two years ago, the Board, very much led by the chief executive So that’s what we’re trying to do now. So that

everybody – ...should, you know, that were customer facing, should do customer care training. But it's taking a long time to get through a workforce of 7500." [Dep Chief Nurse]

In 2008 the site trained more than 1,000 staff in customer care and planned to have at least one customer care trainer for every ward and department by March 2009.

"I think customer satisfaction or customer training ... I think that's very important as well actually – a good example is somebody coming in to outpatients and just being asked to hand over their card and then just be told – 'Go and sit in the waiting room, someone will come and call you.' Rather than, 'How do you do? Whose clinic have you come to?' I know we don't do that.. and that's such a simple thing to sort out." [Med Dir]

Although the Deputy Chief Nurse noted:

"I think that there has been resistance to it. People don't see everybody as customers. I think that some of the people that we've had, you know, the early people through the training, are people who have an interest in it, were good at it anyway. And I think that there's people actually who don't see that we're here to serve, or see each other as customers. You know, internal customers as well."

In the 2007/08 annual report the Trust highlighted other specific initiatives relating to 'involving patients':

- *Patient Experience Tracker:* Oakfield purchased 10 electronic handsets in November 2007 and these were placed in wards, waiting rooms and departments where volunteers would ask patients a series of five questions. From November 2007 to August 2008 there were 4,148 responses for all areas using the devices. A report to the Trust Board in September 2008 noted that: 'The results from the Patient Experience Tracker System allows the Trust to survey more patients than the national patient survey programme and allows analysis of data at ward level which the national survey does not. The results are a lot more immediate and allow for instant action planning.'
- *Patient Council:* the Trust established a new Patient Council to 'give patients greater involvement in every part of our hospitals'. The PPI manager explained that the Council was the former PPI forum and that the Council provided 'a very, very good gauge of what's going on ... they go out and speak to other patients.'
- *Staff training in need for patient privacy and dignity:* the 2007/08 report states that the Trust 'is currently expanding a ground-breaking project that is unique to our Trust.' The project began as a pilot to train staff on all aspects of care including privacy, dignity, spirituality and bereavement. It was led by the Chaplain and included the PPI manager on its steering group who saw 'a lot of power there ... there is a lot of good work being done out there by the trained staff. I think the problem has been is giving them the time to do that.'" The Director of Nursing agreed but felt that without local leaders supporting the work of the champions then there was a danger of potential benefits not being realised. As well as difficulties of

maintaining momentum the other challenge - identified by the Chief Executive and posed to the leaders of the programme - was how to integrate the training programme into other organisational initiatives.

Investing in staff

From the time of appointment the Chief Executive said that “we would look at the capability of the line management as being the driving force behind staff behaviour.” The assumption behind this chosen approach was that:

“the mood of the organisation is driven by the team. And there are thousands of teams, so how can we get team leaders to do better? ... what we then said was, ‘Okay, let’s look at, can’t look at the team level, so let’s look at the middle level.’ ... what are we doing for them... I went and met people and said, you know, ‘You’re a manager, you’re in charge, you’ve got a job to do this, you’ve got to lead a team, what training have you had? ... And every single person I met, bar one or two, said, ‘I’ve had no training, no training to be a manager.’ And I said, ‘Have you had training in leadership, do you know anything about human resource management, much about the law? Have you got the skills, are you equipped to do it?’ And the answer was pretty much universally no.” [CE]

‘Step zero’ [as described by the Chief Executive] was to try to establish what the organisation’s values and staff behaviours were, and to then redesign the induction programme on that basis:

“I put myself on the induction programme, pretty much nodded off during the programme for two days, felt as though I wasn’t motivated by it. And considered that that’s where we needed to start ... then we went back and said, ‘Well hang on a minute, ...what are you trying to say about the organisation? What are you saying through its values, what are you saying how we should work around here?’ So at that point we said we needed customer service training, because we knew the people who were already in the system hadn’t got the right message(and) we hadn’t actually set out what [the right message] was.” [CE]

One interviewee described their experience of the previous induction programme:

“When I first started, induction was four hours long and it just told you how not to set yourself on fire. And how to pick up a ream of paper. It was tedious. And I just came out of it and I remember ringing a friend and saying, ‘God knows what I’ve come in to.’ It was so, so bad. And again that just sort of shows really. To me it demonstrated you’re giving the staff the absolute bare minimum that you have to give them, and it was obvious.” [Equality & Diversity Manager]

The starting point for addressing these shortcomings was the customer service one-day training course mentioned above, which asks staff to look at their own experiences as customers and refer those experiences back to the services they provide within hospitals. The 2007/08 report states that ‘hundreds of members of staff have been trained in specialist customer care to make sure patients are getting the best possible service.’ Eighteen

months on and the induction programme still *“wasn’t doing everything we wanted it to do”* [CE] but *“it’s a heck of a lot better than it was and it’s started off really well.”*

Our interviews also suggested a lack of investment in leadership development previously had led to a shortage of leadership capacity and capability at the middle levels of the organisation; this deficit was perceived by interviewees as leading to poor communication with front-line staff and insufficient attention being given to supporting staff and their wellbeing:

“we have done a number of things that aren’t helpful to that level. We have restructured several times over the last ... five years ... and largely recycle people through different job roles and nobody’s stayed in a role long enough to either be supported by their own direct line manager and developed into the role they’re in ... and our staff wellbeing survey, the national staff survey clearly identifies that line management ... at that level is a problem for us. And, comparatively, a bigger problem than other organisations.” [Dir Nursing]

“I think this is tough, I think it’s a tough, ... I think staff work incredibly hard and they’re very dedicated and committed and I feel that that middle level of managers are really sort of ... different directions and don’t have people as the forefront of their role. And I would say that’s very different to M&S [Marks & Spencers] for example, where managers were really, really well trained in terms of people management and we’re looking at that at the moment. I mean one of the things that we’re doing is, is really investing and focusing on our middle management development programme.” [Dir HR]

The Chief Executive also therefore encouraged the creation of a programme for ‘top’ 300 leaders in the Trust called ‘Performance Plus’:

“My view is that Performance Plus programme is the biggest single intervention we could make to equipping people as managers. Now they outcome of that is, what I’m looking for is the embedding of values and behaviours, that they have the skills to know what managing people means. And that the values and what’s important in this organisation, really gets down to the front-line.” [CE]

But as the Chief Executive recognised “the evidence from my perspective is not compelling that I can fix this situation from just a development programme.”

Postscript

After our Phase I fieldwork had been concluded - in the summer of 2009 - the Chair of the Trust Board resigned and the Chief Executive went on sick leave for stress. Such departures of senior staff were in keeping with a long-term history of instability at senior levels in the Trust. Perhaps not surprisingly therefore our fieldwork suggested little constancy of purpose, or strategic direction across the organisation but rather a series of isolated initiatives (for example, customer care training). Although there was some innovative work underway (for example, the privacy and dignity training

project and the use of 'Patient Experience Trackers') this appeared to be marginal to the more immediate financial and governance challenges facing the organisation.

5.2.2 Organisational context: Elmwick

A high performing Foundation Trust

Elmwick is a relatively large and high performing first-wave NHS Foundation Trust employing 7,000 staff and 700 volunteers. It provides clinical services to a local population of 500,000 people. Thirteen directorates are responsible for the delivery of clinical care through 51 specialities with the support of clinical diagnostic departments and therapy services. The Trust has 1,170 beds and responds to approximately 500,000 patient attendances a year. The total income received by the Trust in 2007/08 was £455 million, approximately £252 million of which was spent on salaries and wages. Fifteen per cent of the workforce is from ethnic minority backgrounds. Services are delivered at two hospitals and more than 14 other locations (through outreach to community and neighbouring hospitals). The vast majority of these services are provided at one main hospital site.

Elmwick has won several national awards for its drive for transformation to raise standards in five priority areas that include: improving care and safety, improving the patient experience and ensuring clinical excellence and effectiveness. In 2009 the Healthcare Commission looked at how well Elmwick performed in a number of different areas of interest to patients and the public; the scores showed that virtually all of the standards were met. As the Chief Executive described:

"well before my time, there was good morale here, relative to other NHS Trusts. You know, I mean morale is always relative. And you know, I think [Elmwick] is a special hospital, the staff are proud of working here and the community is proud of this hospital and the community loves the hospital. So that's a special relationship and it has a very clearly identified community."

Below we highlight several features of the Trust - and internal organisational initiatives - that appear to have played a role in establishing it as a relatively 'high performing' organisation in terms of staff wellbeing and patient experience. These included:

- Formal staff wellbeing initiatives across a wide range of activities.
- A Leadership Academy for senior clinicians and managers (which includes a focus on patient experience).
- An organisation-wide exercise to set staff priorities, expected values and behaviours and then embed these in the HR processes in the trust.
- Formal roles, structures and interventions for ensuring patient experience was seen a priority throughout the organisation, and
- An explicit recognition at senior levels of the importance of the relational aspects of patient experience and how this links to quality more generally.

Relatively high levels of staff wellbeing (and organisational investment in staff wellbeing initiatives)

The staff 'job satisfaction' scores at Elmwick are consistently higher than the national staff survey average and staff also typically report lower 'feelings of work pressure' over the last four years. Furthermore, the Trust has also been rated as one of the best places in the country to work as a nurse. Elmwick routinely commissions a six monthly 'employee engagement' survey that is conducted by IPSOS Mori and 'is evidence-based and unique to the healthcare sector'. The survey measures levels of job satisfaction, how valued staff feel, staff pride in the Trust, levels of discretionary effort and advocacy on behalf of the Trust and how motivated staff feel to make a difference to patients (even if they do not have direct patient contact). As part of one of the organisation's priorities ('valuing our staff and patients') the Trust also supports an extensive programme for their staff, the objectives of which are to:

- improve the quality of life – happy and healthy staff
- establish a truly engaged workforce – staff who are enthusiastic, motivated, productive and network well
- reduce sickness levels and improve retention
- bring some fun into the organisation
- build relationships with health organisations and partners.

The programme included healthy eating and exercise advice and ideas, staff health check days (including a staff weight management programme described as the 'first workplace weight management programme of its kind in the UK' that was launched in spring 2009), public health road shows and awareness days, free exercise classes, de-stress, pamper sessions, walk to work, cycle to work days, and a leisure centre on site:

"We've had world music, salsa classes, we've got any number of sports things going on in our - we've got this pub social club gym. We've got one of the largest gyms in [the area] we operate here. Which is largely for staff, but some others are welcome. So we try to offer a comprehensive, health, wellbeing social activities ... we're trying to create a family atmosphere where people feel valued and where they can achieve their best." (Chief Executive)

Leadership Academy

The Assistant Director of Organisational Development explained how they had asked the Chief Executive when they took up post, "What do you expect of an organisation of this size in terms of leadership development? And before you answer ... I've got £4000." The chief executive said that was "absolutely ridiculous" and decided to make a much more significant investment in a leadership development programme (the 'Academy') from an international company which included a series of four workshops (one of which was on patient experience). The Trust insisted on incorporating one of their own local case studies into each of the workshops; in the case of patient experience there had been a well known case where a patient had been treated very badly and the patient's children had given the Trust

permission to use their experiences for staff development and learning purposes. And so the workshop focused on what is a great patient experience and what had gone wrong in this particular case, and how could the Trust ensure that nothing like this ever happened again. The Trust also insisted that each participant in the workshop had to undertake a project relating to understanding and improving patient experience. At the time of our fieldwork over 200 clinicians and managers had participated in this one-year leadership and management development programme. Participants were also required to exercise their leadership skills by completing a project that directly impacts on improving patient care and patient safety. As the Chief Executive explained the approach was being cascaded through the Trust and made available to senior ward sisters:

"we developed a Leadership Academy for the senior sister and middle manager level, developing the staff. When I arrived, the leadership budget was £4000. So I mean we've just, we try and develop about 200 staff a year, about £1000 a head. So it's investing in the staff, giving them opportunities to grow ... Last year we added a special sub component of that just for the senior sisters. My mental model, frankly, for nursing, is a circa 1975, 1976, when I was a junior doc and the ward sister was God. And I want to go back to that model ... We want strong leadership at the ward level by nurses who ... can manage and they can lead, but they are also clinical nurses and they have the credibility, because they are clinical nurses." (Chief Executive)

A listening exercise: setting organisational priorities, values and behaviours

The Chief Executive explained how they had set in train a listening exercise to establish priorities for staff working in the Trust and the values and behaviours staff were expected to display. The initiative began by gathering about 5000 statements from staff, patients and other stakeholders as to what the values of the organisation should be; these were then 'whittled down' to 'Kind, Safe and Excellent'. Operationalising these values began with staff from the organisational development team asking 'what would 'Kind', 'Safe' and 'Excellent' look like?' in terms of staff behaviours - and considering what the organisation would not accept - and then amending various HR policies and procedures (for example the Management Performance Policy, the appraisal policy and the local implementation of the National Knowledge and Skills Framework). In order to (in the words of the Chief Executive) 'make the values a living entity', senior managers and clinicians throughout the Trust were being given the strong message that 'unless you role model this behaviour, unless you live and breathe them, and you are loyal to them, your staff will not follow them.' Significantly attention was also being focused on ward managers and - over a period of 18 months - every member of staff would go to an event where they would be briefed about the values which would then be reinforced, firstly, through appraisal processes and, secondly, through making attitudes and behaviours an explicit part of the trust's Performance Management procedure. This targeting of ward managers was partly driven by as a response to what the Director of Patient Experience termed the 'glass

ceiling' at operational manager and ward manager level: "We take a good nurse, 'You're a great nurse, now you can manage this ward, you I can have 50 staff, a budget of £1 million, but we're not going to tell you how to deal with HR issues, we're not going to tell you how to deal with budgets, we're not going to tell you how to build a team, we're not going to tell you now to performance manage,' and then we wonder why they fail basically".

Structuring the organisation for quality

The Trust has several organisational features that mark it out from most NHS Trusts in terms of its commitment to recognising the importance of - and improving - patient experience.

Firstly, at the time of our fieldwork senior leaders at Elmwick were strengthening nurse leadership and the organisational structure largely in response to a felt need to improve patient experience. The Chief Executive perceived this restructuring as aligning to a quality management philosophy and changes at the top of the organisation. A new combined Director of Organisational Development and Chief Nurse role, and a Director of Patient Experience Board-level post (see below). Changes were being cascaded down the organisation, firstly, through the introduction of a new senior nurse role with the remit of improving patient experience and safety, and secondly, a focus on clinical role modelling and leadership and care at the bedside. This manifested itself in a new set of job descriptions for senior nurses which included explicit statements about the amount of time they were expected to spend in direct clinical care. The job descriptions were written in the style of 'Kind, Safe and Excellent' (see 'values' work above) with an emphasis on role modelling, standards of care, and patient experience.

Director of Patient Experience (and a targeted intervention to improve staff wellbeing and patient experience)

Secondly, the creation of a Board-level Director of Patient Experience post is notable because very few other acute NHS Trusts have such full-time or senior roles; often the role is performed by a Deputy Director of Nursing or equivalent. The postholder at Elmwick had a very strong belief that the services in the Trust were not making the most of the 'wealth of information' relating to the experiences of their patients; they noted 'massive potential in this organisation - we do lots of great things - but we take a big 12 bore shotgun and shoot ourselves in the foot by failing to learn what I think Monty Python called the 'bleeding obvious.'" The Chief Executive explained how they perceived this role:

"I created a Director of Patient Experience [role] well before the NHS kind of discovered that sort of stuff. And we focused upon improving our feedback. We've taken a few garden path journeys and cul de sacs and whatever, but I do think that we are making serious progress now ... to be somewhat removed from the rest of the organisational structure, to be there as a, a friend of the patient, who would advocate on behalf of patients, to take their perspective, to make sure their perspective was heard at the executive level and also to utilise all the opportunities from

complaints and suggestions for improvement, and to be able to link in directly to quality." (Chief Executive)

As part of their role ("I'm the person that should be championing it, making sure that it's seen as a high priority in the organisation, living it ... being a thorn in the sides of people who are not looking at their service and not learning from the wealth of rich information that we've got from all the proactive, constructive feedback to all the negative complaints"), the Director of Patient Experience, working with the Director of OD/Chief Nurse, had established an organisational development intervention targeted at poorly performing services in Elmwick:

"through the [OD intervention] where it's particularly poor, we also try and do it through, as I say, sending our PALS to the clinical governance meetings and talking through complaints ... the principles are that the team works with the managers of those areas, and together they determine what the particular training issues – the issues are that need addressing through the training. So it's something that's done with the team, not done to the team. And I think that's absolutely important."

Staff in the team reporting to the Director of Patient Experience noted how although the Trust has 'so many mechanisms now of getting [patient] feedback ... what do we do with it?' The team agreed that they would identify - from the feedback - service areas where they thought that attitudinal issues, customer care issues, patient experience issues needed to be addressed. They described the nature of the intervention in the following terms:

"None of the three of us that are involved are clinical, we can't go in and train people on how to give kind care, or whatever. But we can talk to them about what patients and the public have said about them ... it's the kind of reactive [patient complaints], proactive [patient engagement], and then the HR [values and behaviours] bit thrown in as well, What we could never have foreseen, and I don't think anyone could have done, including the managers of the areas that we've been in to, is just how much the staff would tell us ... the Associate Director of Operations with responsibility for the [service area] said, 'There is stuff that you've got that [from the staff] we have never been able to get them to tell us'".

The team devised a questionnaire that sought to 'tease out' what it was like for staff working in a service ("Before we go in, so we know we're delivering the right training, we want the staff to tell us what it's like"). The intervention took place over a number of sessions provoking strong reactions from some staff:

"... I took some really quite startling quotes from complaints, which reduced some staff to tears. We had one member of staff, I think, in the third session, who said that she felt that she should resign – it wasn't about her, but she felt so ashamed of her colleagues, that her ward was thought of in that way, that she felt she should resign. She wasn't a senior member of staff at all. But she said, 'I don't think I can continue.' But we kind of got round that. We also got some compliments laminated as well,

and used them, particularly around the role modelling ... So, 'this is what patients and the public have said they liked about you, what was good, now you take that to the next level and think about what makes it good for you. What is it about these compliments and what you know of individuals that makes them role models.'"

The Director of Patient Experience described an intervention in one particular service as having 'opened up a can of worms that they weren't expecting'. The ward staff were very grateful for the opportunity to raise concerns and issues that they had had for a long time ('the department had been a significant problem for at least 18 months, with really awful complaints') and the intervention was the catalyst to having a senior clinical nurse removed from her post.

Recognising the importance of 'caring' in the patient experience (and quality more generally)

The Chief Executive clearly understood - and was able to explain the importance of - relational aspects of patient experience in the context of a broader quality framework:

"this is not just about being good at clinical science, but it's good about caring, you know. ... [patients] haven't a clue what's going on most of the time. However they can judge whether you're being dismissive, rude, whether the toilets are clean and, you know, all aspects of quality ... it's a paradigm actually getting the staff to realise that they're on stage all the time and that they need to respond to that and to be caring, because ... our patients are emotional, because they might be dying or they're worried and anxious ... There is an emotional overlay in healthcare which is different, and I always try and stress that at orientation that, you know, the staff have to be able to engage emotionally in a caring attitude with our patients. It's absolutely core to healthcare." (Chief Executive)

The Assistant Director of Organisational Development reflected on the way in which the Chief Executive had raised the priority accorded to patient experience in the Trust:

"[The CE has] probably made it a lot more explicit. And, you know, from day one, it was, 'I want the patient experience to be the best it can be,' you know, and [s/he's] very powerful when [s/he] speaks at induction. [S/he] makes you want to cry actually sometimes, when [s/he] speaks, because it's about, you know, 'It's not like you're working in an organisation where people are going to be in a post office queue. These are people that come on to our site and they are terrified. And it's your job, no matter what role you're in, to make a difference. We want you to want to make a difference.'"

Summary

There was a marked contrast between the organisational contexts of the two acute Trusts in our study (Oakfield and Elmwick). As described earlier Oakfield was in a precarious financial situation with many other pressing short-term priorities (including external concerns about staff wellbeing) that

need to be addressed at a senior level. Whilst efforts were being made to heighten attention to patient experience at Oakfield the initiatives underway appeared piecemeal and vulnerable to these other priorities. In contrast, Elmwick was a relatively much more 'successful' (and stable) Trust with a much longer track record in attempting to systematically address patient experience as a key priority. Significantly, the ongoing work around staff values and behaviours, a clearly focused leadership development programme, and the redesign of roles and structures relating to organisational development and patient experience were all taking place in the context of a broader quality framework. In later chapters of this report we shall observe the extent to which these differing organisational contexts shaped the wellbeing of staff and experiences of patients in front-line, clinical microsystems.

5.2.3 Organisational Context: Ashcroft Community Health Provider

Background

Ashcroft Community Health Services serves a large outer city borough and an unusually diverse population of 337,200 including a large and mobile population of asylum seeking families in some areas. Health Indicators (329) suggest that residents across the borough have better than average health than residents across England. Many neighbourhoods served by Ashcroft organisation, along with the borough as a whole, are notable for their extremes of affluence and deprivation.

Before 2008 the PCT received consistently 'Good' Health Care Commission Annual Ratings for its 'Use of Resources'. In 2009 the new Commissioning Directorate was rated as 'Good' for its 'Quality of Commissioning' and the 'Quality of Financial Management'. The organisation that included Ashcroft is notable for its exceptional speed at progressing the TCS national agenda.

At the same time, the Health Care Commission Annual Ratings (2005-8) on the quality of primary and community health services within the former PCT had been consistently 'Fair'. Two service reviews (2007/8) rated services for people with long-term conditions as predominantly 'Fair'. The Chief Executive's Report to the Board (2009) noted that Annual Health Check for Ashcroft (along with primary care services) were 'disappointing but unsurprising [given that this city's] PCTs scored worse in quality of services and performance than any other NHS region...'.

In 2008/9, with the process of organisational separation underway, Ashcroft Community Health Services had an annual budget on £36 million. In 2009, the Ashcroft directorate included district nursing, health visiting, and allied therapies. The directorate employed about 800 staff, including 300 staff in children's services and 450 staff in adult nursing and allied health as well as nine community matrons; four nurse consultants and some designated nurse specialists.

Organisational priorities and effects

- Through 2008/9 Ashcroft was completed an independent review to organise for 'business readiness' (to become a fully independent service provider organisation). This review concluded that Ashcroft was not viable as a stand-alone business and, though 2009, a range of mergers were under consideration. In 2008/9 management focus was on enhancing service productivity in addition to improving, or sustaining, the quality of community health services. Many Ashcroft managers noted the felt contradictions between service efficiency and quality in front-line patient care. These managers were also concerned about their own work futures.
- Concurrently, PCT service commissioners launched its 'Better Health for a Better Future' strategy (a 10 year plan for improving primary and community health services across the borough). New service alignments, to ensure more 'joined-up' care for patients, involved changes in management structure (with some middle management posts re advertised) and in work re locations for some direct health care staff. One Head of Services (who subsequently resigned their position) felt these changes to be "unsettling.. un-stabilising.. ..at a delicate time...we've been through so many changes and now we're going through another...not very wise, no, no, no..."
- Interviews with Ashcroft senior managers identified felt frustrations with both the speed of change towards the TCS agenda or the priorities or outcomes of service commissioning arrangements.

Patient experience

In 2009 organisational responsibility for monitoring patient experience and satisfaction were flagged as a world class commissioning competency and, in commissioning services for Ashcroft, monitoring structures and processes were in development. In late 2009 there were no established indicators for patient experience for community health services.

Knowledge of patients' experiences of care in Ashcroft was 'ad hoc' and limited, drawing from several sources, notably:

1. An annual 'in service' patient survey that was undertaken within some Ashcroft services and circulated to the organisation by some services. The Head of Quality and Patient Safety noted that these surveys were not systematic and that administrative staff lacked the capacity to process survey findings across the organisation. There was, however, a web-enabled governance information data base that allowed all service reports to be made available to senior managers at Ashcroft.
2. Occasional and secondary patient survey data summaries sources such as:
 - a. Summary findings from PCT commissioner strategy planning (2008/9) that noted for Ashcroft (and primary care services) patient survey and engagement work reported "poor experiences of accessing and using services".

- b. Patient and carer consultations (including those for the 'End of Life Care Baseline Review' (2008); 'Big Question' week and 'Healthcare for the City' initiative) which suggested that Ashcroft (along with primary health services) needed to "create time for health staff to understand the wishes of patients and carers".
 - c. A series of deliberative workshops (in 2008) with 200 Ashcroft borough residents found some inconsistencies in Ashcroft and primary care services as well as some difficulties with access and disjointed service delivery. For Ashcroft, in particular, the workshops report noted the need for an improvement in staff attitudes: "people felt that staff could be unkind, lack warmth and that people often did not feel treated as a human being".
3. Complaints and Compliments Reporting. All Assistant Directors and Senior Heads of Service for Ashcroft reported that they together received no more than eight patient complaints each month (and that 100% were responded to within 25 working days). However underlying this reported data was a complex system of informal complaint management by some service managers, senior clinical staff and PALS. The Director of Ashcroft was keen to note that "We get far more compliments [than complaints] and it is nearly always when people have died at home. So we do know that in spite of all the odds stacked against us there is some good care going on."
 4. The 'One Thousand Voices Patient Experience Project', a methodology for collecting patient narratives and for sharing these across service areas, that was initiated in provider services by a previous PPI Project Director (prior to commissioner/provider service separation). The aim and methodology of this project was unclear to most managers in Ashcroft and, as the Head of Quality and Patient Safety noted, Ashcroft lacked the organisational structures and resources to sustain this initiative. They described how "one Nurse Consultant collects [patients stories] and just files it.. [s/he] doesn't know what to do with it...I've asked all our teams to file it...I just have to have the time to talk to my manager to ask how we are going to use them"

In all, some Heads of Service noted the value of a more systematic focus on patient experience within the organisation. Meanwhile some senior managers felt that individual services were better placed to survey and respond to their patients' needs. Nevertheless, the Head of Quality and Patient Safety for the organisation noted the sometimes poor and often variable quality of patient experience "ranging from probably gold standard, gold star to less than we would aspire to". Senior clinical staff interviewed were especially critical of variations in standards of patient care and care experience with some noting that "[care] is very fragmented"; "[patients] feel like they're the bottom of the pile.. [like] they're written off"; patients feel that "they have no control over [their care]".

Staff wellbeing

The 2008 National Staff Survey (which included Ashcroft within the Primary Care Trust) presented a mixed picture of staff wellbeing. The PCT scored in

the highest 20% of PCTs in England for 6/36 indicators and in the lowest 20% of PCTs for 8/36 indicators (including reported work pressure and feeling undervalued by colleagues). In addition, between 2007 and 2008 fewer staff reported feeling valued by managers while satisfaction with work had not altered significantly (it remained below average for PCTs in England).

Senior managers in Ashcroft tended to attribute poor scores for the PCT to the poor staff experience in commissioning services as well as to the 'leading questions' asked in the survey. Nevertheless, the Director of Ashcroft reflected that "we do have a long hours culture... [staff] may feel they have to.. so there must be some wellbeing element of that". HR representatives noted that poor staff experience in the organisation was often a matter of perception rather than fact.

In 2008/9 the 'year end' vacancy rate averaged 19.5% across the PCT with some Ashcroft services having the highest rates (reported to the researcher as between 19%, 25% and 35 to 40% in some service areas and with 33% of these vacancies filled by agency staff). In 2008/9 Ashcroft had an average staff absence rate (3.50%), which is lower than the mean for community health organisations. Long term vacancy rates were a financial and service quality concern for Ashcroft. An HR workforce of that year predicted the negative long term impact of these rates on staff sickness rates and on patient care performance. As in the national workforce profile of adult community health services, the demographic profile of staff in key Ashcroft services was heavily weighted to older and long established employees. HR and service managers explained both these staff vacancy rates and workforce demographics in terms of the particular geographical position of the organisation (where younger qualified could earn more working in an adjacent borough and where property prices in the borough were high). Managers also acknowledged the national shortage of qualified and experienced community health staff and the particular demands of clinical work in the community for less experienced nurses.

Several managers noted a history of depleted, inefficient or detached HR management. Indeed the HR representative interviewed commented that poor staffing in some service areas was a matter of perception rather than fact. The HR department was felt to have very limited resourcing and to be focused on formal disciplinary processes and workforce trends. In early 2009 HR commissioned a web-based staff survey on staff wellbeing, values and behaviours. That year the provider services organisation had received no feedback on this work.

Overall, general and clinical managers felt that staff wellbeing amongst direct patient care staff was poor or very poor. Many managers were highly critical of the demands and effects of agreed commissioning contracts in many provider services. Several noted that these contracts had left staff "over worked and feeling undervalued". The Director of Provider Services commented that, in some services, a "vicious circle" of an under established workforce, high staff turnover and increasing [performance] demands existed. Some managers were also aware of poor working practices in

these services however the Director noted that some service areas had acquired an undeserved poor reputation.

Organisational structures and initiatives to support staff

Managers noted that a vast range of organisational structures (many of which were recently relocated into commissioning services) as well as numerous initiatives to support staff in Ashcroft existed. These included:

1. Existing management structures (Assistant Director meetings; the Professional and Clinical Advisory Group and Standards and Governance Committee). However these forums dealt with service performance as a priority. One AD noted "although I have lots of staff, I sort of feel slightly as if I'm just hoping that they're getting on with it really.... we are too busy recruiting staff to worry about their wellbeing..."
2. Occupational Health Services. Since 2008 this had focused on 'return to work' support and work place assessment remit with a reporting structure to HR and had developed its counselling service.
3. Advisory groups ('Group Dignity Champions Scheme'; 'Improving Working Lives' group).
4. Staff acknowledgement schemes (Long-Service Awards Ceremonies; Governance Grammys).
5. Investment in staff training and clinical supervision was a high priority in Ashcroft (provider services). In 2009 staff training included 'Cultures and Values in the Workplace'; NVQ in 'Lean Thinking'; 'Leadership at the Point of Care'; various clinical and practice training initiatives (with nurse consultants) and learning sets (some with external facilitation). Scholarships and sponsorships were available to senior clinical staff for HE study and 'cutting edge' clinical training and HE bursaries were available for unqualified staff. At the same time, senior clinical managers noted the mismatch between training opportunities and poor workplace leadership and staff shortages.

Overall, managers recognised the marked disjuncture between organisational structures and initiatives to support staff wellbeing and the experience of staff in the workplace. One AD remarked on the limited achievements of the organisation to make "the loop from [organisational innovation for staff wellbeing] and empowering and engaging staff". The Assistant Director of Adult Community Services commented that "we're lacking organisationally on an emphasis on valuing [staff]" and one senior clinical manager remarked "there's a policy for everything [concerning staff wellbeing] if you've got time to find it!.. and staff still feel worn out and unvalued".

Summary

At the time of the research Ashcroft organisation was in the throes of exceptional change, particularly with respect to the speed of the TCS agenda developments, and the demands of contracts with commissioners and potential organisation mergers.

At the same time, however, ad hoc data suggests that Ashcroft has a longer history of variable or poor patient experience in at least some services. Most general and clinical managers felt that staff wellbeing was poor and most considered that the demands of 'business readiness', along with front-line staff shortages due to vacant posts, explained poor staff wellbeing. The organisational strategy for improving staff recruitment and retention (and improving service efficiency and quality) was substantial investment in staff training.

At the same time, however, clinical managers were aware that, in the shorter term, staff involved in direct patient care were stretched, stressed and working beyond their capacity.

5.2.4 Organisational context: Larchmere Community Health Provider Organisation

Background

Larchmere is a comparatively small community health provider organisation situated in a large Regional Health Authority in the north of England, serving a largely stable population of about 200,500. The NHS 'Health Profile' (2006-9) of this population describes it as 'similar to that of England for many indicators' but with marked differences in deprivation levels compared to the whole of England. In 2007/8 Larchmere was one of the least well served areas for primary care provisioning in the country. However, by 2009, new primary care services and facilities had been opened or were due to soon open.

From 2006 the overall performance for Larchmere PCT had increased year on year according to Health Care Commission Annual Health Check Ratings. In 2008, when Larchmere became a separate directorate within the former PCT, the organisation managed a budget of £17 million.

It provides Adult and Children's Community Health Services that include an Adult Nursing and Matron Service (with 260 to 300 staff divided into 19 to 20 teams); School Nursing and Health Visiting Services (with 150-170 staff); a Substance Misuse Service (with 50 staff); a Health Improvement Service (with 35 core staff); and staff and management towards a multi-agency Rapid Response Team (17 staff).

All managers interviewed reported a history of good operational planning and working relationships between the former PCT and the single and co-terminous local authority. They felt these relations were important for the good effective functioning of adult and community health services as well as for good working relations between community health and social service staff.

Contrasted to some community health service organisations, Larchmere had progressed slowly towards the Transforming Community Services (TCS) agenda. Many managers noted the advantages of the measured approach of the Strategic Health Authority towards these national reforms. Managers noted that, irrespective of the ongoing processes of staff consultation within

Larchmere, staff and patients will soon feel the effects of service upheavals and of closer performance management on front-line services as the TCS agenda was implemented.

Patient experience

Before the separation of Larchmere organisation from the PCT, reporting on patient experience had been the responsibility of the Public and Patient Involvement Manager. In 2009, with the PPI team now situated in the commissioning arm of the service, the PPI Manager felt that their role and remit was unchanged. However the Head of Quality and Patient Safety within the provider arm felt that the priorities and processes of patient experience survey work within the two arms were different.

Due to the limited emphasis on the systematic collection of patient satisfaction and patient experience data in community health services nationally, as well as the recent division of provider and commissioner service responsibilities, managers' knowledge of patient experience was, they knew, limited and piecemeal. Managers referred to the following survey initiatives and data sources:

- An annual "Listening to Your Views" survey conducted by the PPI team to gather service-specific patient satisfaction feedback. In 2008 the survey (based on 1400) returns indicated that, in Larchmere, almost 80% of patients felt that the service met their needs and 90% of patients felt that they were treated with respect and dignity.
- Recorded formal complaints (with Larchmere receiving eight complaints in 2007/8 and the organisation responding to all of these complaints within 25 working days).
- Informal, telephone or written complaints (reported to, and managed by, Locality or Clinical Managers). These managers reported that the majority of complaints made to them were about lack of front-line staff availability and resourcing rather than about the behaviour or attitudes of staff.
- Frequent compliments, typically 'good letters' received by community health teams, particularly from 'palliative care' patients and families.

Organisational initiatives

From 2008 several work-streams had been focused on the improvement, monitoring or representation of patient experience. They included:

- 'Privacy and Dignity' (Essence of Care work) in some services.
- 'Patient Experience' survey development (in relation to the Quality Framework guidance).
- Productive Community Work, Institute of Innovation.
- Ongoing qualified staff training initiatives in the Practice Development Unit (PDU) (a unit that included a lay advisor).
- Specific in-service survey initiatives, often short telephone surveys to gather 'snap shot pictures' of patient experience.
- Patient Testimony (video) work directed at two audiences: staff in provider services (available through staff intranet and in staff briefings) and service commissioners (as a "marketing tool" in future board presentations).

Overall senior and middle managers noted that they lacked an overall picture of patient experience within services and across the organisation. For example the Head of Quality and Patient Safety commented that “sometimes you only know [of patient experience] if they come to you [when] it’s actually been an issue, rather than us going to them and saying, ‘How did we do?’”

Staff wellbeing

The 2008 national staff survey found that the PCT (including Larchmere) was ranked in the top 20% for 14/36 key indicators (compared with all PCTs in England) and in the lowest 20% for 1/36 indicators. In this survey 75% of respondents were from Larchmere organisation.

The disaggregated ratings show that Larchmere had a higher percentage of staff using flexible working options; undertaking annual and well structured appraisals; understanding their role and place in organisation; and who would recommend the trust as a place to work. In addition Larchmere has a higher percentage of staff witnessing potentially harmful errors and incidents and a lower percentage of staff having equality and diversity training than across the PCT as a whole.

In 2007/8 staff turnover (all of PCT) was 4.68%. Many managers note the tendency of staff to have trained and remained in the area “so they do know the population well and there’s only a few, a handful really who have come into the area” (Head of Adult Services). The Deputy Director of HR noted that “it’s not easy to get in and out of [site 4]” and particularly for front-line staff there is a “culture of not having to travel for work”. He, too, noted the value of “people who really know the communities they work in” as well as the disadvantages of “becoming focused on ‘this is my job’ in a narrow way”. This manager also noted that long serving front-line staff had ‘loyalty to their local area’ to the extent that localities have sometimes identified against each other over the re-allocation of posts.

In 2007/8 total staff sickness absence rates for the PCT were high (5.2% with 2.9% as long term sickness and 2.3% were short term sickness). All managers interviewed in September 2009 were very positive about the present OH service, noting the quick availability of counselling services for community staff. Following action planning in response to the 2006 National Staff Survey, in 2008/9 the PCT Occupational Health service was contracted to the larger, adjoining organisation and the PCT budget for staff counselling services were increased due to high uptake.

Staff engagement and support initiatives

In 2007/8 a new senior management team was recruited into established and newly created positions (for example Innovation Leadership and Staff Engagement posts). The emphasis of the management team was staff involvement in change and innovation. Middle and junior managers felt that this new team had a positive impact on the organisation and marked a “new start” however few managers were aware of how this team was viewed by front-line staff.

In addition, a longstanding HR team, along with the PCT CEO, had a longer established history of good working relationships with front-line staff. This view was indicated by the deputy manager of HR for Larchmere who described “HRs job [AS] about the interests of staff. We’ve always had a culture of participation and good industrial relations.....because our [PCT] CEs have supported that”

Established and recent initiatives to promote organisational engagement by staff were three fold:

- An ongoing Improving Working Lives (IWL) Group (working across the former PCT) that also supported and helped fund a range of ‘spin off’ work streams (including a “Looking after Me” group to support health and wellbeing in the work place; the ‘Mindful Employer’ Scheme; Mental Health First-Aiders training; and staff ‘stress down days’ in some community health localities).
- An Innovation Council (I.C.) (in Larchmere) that acted to initiate and introduce a range of service and staff development initiatives and to “engage staff from all levels and from different services across with this work” (MD of Provider Services). Work undertaken in relation to staff wellbeing and engagement included a Staff Conversation Programme (based on the DoH NHS Values and Vision work); staff text surveys; strategy mapping; leadership development; and ‘share and learn’ sessions.
- A monthly management forum headed by the MD of Provider Services for junior and middle managers so that “instead of information being cascaded through heads of service and out to them [because] some of the junior managers might play out the [agenda] differently, which can lead to inconsistencies in the localities and in services” (MD of Provider Services).

All Larchmere managers interviewed felt positive about the work of both the I.C. and IWL group although several felt that there was an overlap in their agendas.

Summary

Patient experience and satisfaction in Larchmere appears to have been good however, without consistent and comparative survey findings, the picture is piece meal. It is, however, significant that all managers interviewed noted that it was urgent for them to learn more about patient experience in the organisation and in services.

According to staff survey results and to staff sickness and turnover rates, staff wellbeing in Larchmere was good. The organisation, and particularly HR services was familiar with and responsive to the concerns of managers as well as the situations of front-line staff. Overall managers were very positive about their organisation, particularly regarding senior management leadership style and their strategic work. Managers were less aware of how front-line staff, themselves, felt about the organisation and their work.

The longevity of individuals’ employment in Larchmere, along with organisational innovation initiatives that encouraged front-line staff and

junior managers to meet and work with middle and senior managers, explained this sense of an organisation 'knowing its staff'.

Several managers indicated that low staff turnover was a mixed blessing; with staff knowing each other and their communities well but also sometimes less reluctant to become involved in service change (a recent experience of this was many staffs' reaction to the roll out of the EPR system along with their suspicions over performance monitoring initiatives).

Nevertheless all managers anticipated the forthcoming stresses faced by themselves and their front-line staff teams during immanent TCS transitions. Most managers anticipated that these stressors would be resolved when a final decision on the future of the organisation was clarified.

5.3 How organisational context shapes staff wellbeing and patient experience

Looking across our four case study sites there are several contextual factors that were identified either by interviewees or through our documentary analysis as being important in shaping staff wellbeing and patient experience:

- *Organisational size*: whilst both the acute Trusts are relatively large and each employ approximately 7000 staff, the community service providers have far fewer staff, employing 420 and 540 staff.
- *Organisational governance*: Oakfield is not an NHS Foundation Trust, provides services from four main hospital sites which are geographically dispersed, and was recently found to have poor management in place for workplace related stress; in contrast, Elmwick became an NHS Foundation Trust as long ago as 2004, provides the vast majority of its services from one main site, and is a recent winner of several awards relating to the quality of patient care it provides and being seen as 'a good place to work'. Both community sites have undergone radical transformation in their governance structures since 2007 as part of the process of establishing themselves as separately managed provider services; both faced considerable uncertainty over the future governance of provider services during the research period.
- *Organisational reconfiguration*: one of the community service providers (Ashcroft) has advanced quickly (in relation to other providers in its own strategic health authority) through the Transforming Community Services (TCS) agenda, and has invested heavily in 'in-house' and commissioned staff training initiatives. In Larchmere senior management are actively engaging front-line practitioners and managers with the TCS agenda; staff engagement initiatives have been developed by a clinical leader for innovation reporting to a Head of Innovation & Improvement. During the period 2009-2011 both community service providers were undergoing

significant changes in service organisation as many staff teams are moved into larger primary or community care clusters.

- *Senior leadership:* there was a clear difference between the acute sites in terms of stability at senior levels in the organisations; in Elmwick the Chief Executive has been in post since 2006 and appointed an Executive Director of Patient Experience & Public Engagement who has had time to develop, trial and implement a cohesive programme of work in collaboration with other relevant Directors, whereas in Oakfield there had been considerable turnover of senior staff over a period of several years.
- *Inter-sectoral relationships:* both of the community service providers have a history of good collaborative working with their local authorities, which are co-terminus in each of the community sites; in addition, Ashcroft has a national reputation for some innovative operational working within a well-established clinical management structure.
- *Local demographics:* Ashcroft has a relatively high proportion of Black & Minority Ethnic residents, asylum seekers, and vulnerable children compared to the other three sites.
- *Labour market:* for historical (local and national) as well as geographical reasons one of the community service providers (Ashcroft) has had serious and chronic understaffing due to unfilled posts and rapid turn-over, particularly of experienced qualified practitioners. In this site some areas or teams within adult community services have a poorer reputation than others; managers here are working to improve low staff morale due to chronic understaffing and/or rapid staff turnover.
- *Data collection systems:* without previous national directives or guidance for monitoring patient satisfaction or patient experience, there was little consensus amongst senior managers in the two community service providers as to the overall quality of the experiences of patients being cared for by the organisations (and they were also unsure of whether there was variation between different services); in Ashcroft a 'Fitness for Purpose Review' urged the PCT to make better use of patient experience data and a review of Patient & Public Involvement (PPI) activities led to a strategy document - this seems to have subsequently lost focus as there is currently no PPI manager function at this site.
- *Model of Occupational Health Services provision:* the model of Occupational Health Services differed between the four sites; for example, the provision of an 'in-house' service (Elmwick) compared to an external provider or a partnership (shared) service agreement (Larchmere) has possible implications for the comprehensiveness and responsiveness of the services provided to staff.

Organisational initiatives: improving staff wellbeing and patient experience

Figure 6 summarises the key initiatives underway at the time of our Phase I fieldwork relating to staff wellbeing and patient experience:

Figure 6. Ongoing initiatives in case study sites relating to (a) staff wellbeing and/or (b) patient experience⁵

<p>OAKFIELD</p> <p>(a) Staff wellbeing:</p> <ul style="list-style-type: none"> • Significant redesign of staff induction programme • Extensive leadership development programme • Organisation-wide staff work and wellbeing survey • Dignity at work policy • Management of stress working group <p>(b) Patient experience:</p> <ul style="list-style-type: none"> • Innovative patient wellbeing project • Roll-out of Patient Experience Trackers • Dignity in Care committee • Customer services training 	<p>ELMWICK</p> <p>(a) Staff wellbeing:</p> <ul style="list-style-type: none"> • Major initiative on 'values & behaviours' • Wide-ranging Health & Wellbeing programme • Extensive leadership development programme • 'Leadership at the Bedside' programme for ward managers • 6-monthly 'Employee Engagement' survey <p>(b) Patient experience:</p> <ul style="list-style-type: none"> • Executive Director of Patient Experience & Public Engagement • Innovative organisational development intervention related to patient experience feedback • All patients surveyed after discharge; ward-level feedback
<p>ASHCROFT</p> <p>(a) Staff wellbeing:</p> <ul style="list-style-type: none"> • Workforce Information reporting • Group Dignity champions* • 'Improving Working Lives' • Recruitment & Retention strategy group (PCT) • 'Cultures & Values' in the workplace • 'Leadership at the Point of Care' leadership training <p>(b) Patient experience:</p> <ul style="list-style-type: none"> • Annual patient survey • '1,000 Voices' (to capture patient experiences) <p>* independent advisory group employed as part of action plan related to National Staff Survey findings</p>	<p>LARCHMERE</p> <p>(a) Staff wellbeing:</p> <ul style="list-style-type: none"> • 'Improving Working Lives' group • 'Improving Health, Improving Lives' organisational strategy • 'Innovation Council'** (includes 'Staff Conversation Programme' based on NHS Values & Vision work) <p>(b) Patient experience:</p> <ul style="list-style-type: none"> • 'Innovation Council'** (includes 'Privacy and Dignity', Essence of Care workstream) • 'Listening to Your Views', annual patient feedback <p>** a forum for staff and service users to bring ideas and develop practical solutions to improve patient care</p>

⁵ The initiatives shown are those highlighted by interviewees and are not intended to be an exhaustive list of ALL initiatives relating to staff wellbeing and patient experience, some of which are mandated (such as participating in the national staff and patient surveys, and having a formal complaints process).

Organisational initiatives – staff wellbeing

Typically there was less evidence across the four sites of ‘leading-edge’ initiatives aimed at improving staff wellbeing (compared to those seeking to improve patient experience), with the exception of a widely recognised and leading Health and Wellbeing programme at Elmwick which also undertook six-monthly internal surveys of ‘employee engagement’ (covering issues such as job satisfaction and staff motivation to make a difference to patients). Oakfield had also undertaken a major organisation-wide ‘Staff work and wellbeing’ survey, the results of which are informing ongoing work with staff within specific services. There were notable differences between the two community organisations in their approach to engaging and supporting front-line staff. Ashcroft organisation invested heavily in staff training initiatives as well as training and higher education sponsorships in order to retain staff and to enhance clinical and interpersonal competencies. In Larchmere organisation emphasis was placed on staff engagement in service and organisational innovations (through working groups, mixed staff forums, networks and the use of ‘team representatives’).

Organisational initiatives – patient experience

There is innovative work relating to improving patient experience underway in each of the four sites using different technological approaches and/or organisational structures and systems. For example, Oakfield has been using electronic ‘Patient Experience Trackers’ since late 2007 and is rolling these out across the organisation; Elmwick trialled the same devices but is instead now using a local patient survey which is sent to all patients when discharged and provides ward-level feedback. Oakfield has also developed a programme to improve patient wellbeing and has delivered this to various cohorts of staff groups with participants trained on all aspects of patient experience including privacy, dignity, spirituality and bereavement. Ashcroft has initiated an annual “Listening to Your Views” service-specific patient feedback questionnaire; similarly in Larchmere an annual patient survey had been adapted, administered and was intended to be reported by each service but neither community organisation had an - as yet - systematic or routine method to survey patient experience (in both organisations initial developments were undertaken prior to changes under the Transforming Community Services agenda and those teams responsible for these developments had since been relocated into commissioning organisations). In Ashcroft ongoing patient safety concerns overshadowed the limited time available for the development of monitoring systems and interventions to improve patient experience. Thus several prior initiatives to access and improve patient experience (developed by staff now part of commissioning services) remained undeveloped or were abandoned within the provider organisation. Patient satisfaction surveys were occasional, unsystematic and reported only within services. In 2010 highly selected findings from a patient satisfaction survey in one of the poorest performing services in this organisation presented patient satisfaction in a very positive light in order to support and motivate front-line staff. In Larchmere the organisation was concerned to develop more robust mechanisms however senior staff within

this provider service were unsure of how to develop these. The annual 'patient views' survey continued for each services however these findings went to service commissioners rather than directly to Larchmere.

Other, broader, organisational initiatives were also underway which related, at least in part, to ongoing efforts to improve either staff wellbeing or patient experience (or both). These can be broadly categorised as interventions to (a) help develop leaders and managers, and (b) interventions to embed 'values and behaviours'. With regard to the former, the two acute sites had both recently launched leadership and management development programmes for hundreds of their clinicians and middle managers; these programmes reflected a common concern across the four sites that there was a shortage of leadership capacity and capability at middle levels of the organisations. This was perceived by interviewees as leading to poor communication with front-line staff, leading to little attention given to supporting staff and their wellbeing. With regard to the latter, work was underway in all of the sites. For example, both acute sites were actively involved in organisation-wide initiatives to establish and assimilate the 'values and behaviours' they expected from staff and behaviours that they would not accept; the results of these initiatives were being embedded through appraisal and recruitment processes, and the redesign of induction programmes, although one of the sites was further along this 'journey' than the other. Both of the community sites are also undertaking work with front-line staff on 'Cultures, Values and Behaviour'.

In short, however, the extent to which such work was seen as a priority and adequately resourced - and the results used to inform organisational decision-making processes - varied. In Oakfield and Ashcroft such work as that described in the preceding section did not appear as central as the more immediate, short-term challenges facing the organisations.

5.3.1 Perceptions of senior managers: Phase I

Three themes were identified as central to managers' views on staff wellbeing.

First, staff wellbeing was identified as a poorly understood dimension of organisational, service and individual work performance for many managers. It was rare for any of the interviewees to volunteer a view of staff wellbeing as more than an obvious, immediate and individual behavioural attribute. Staff wellbeing was occasionally discussed as the absence of work-based stress or tiredness (conditions that were assumed to be part of working lives during especially busy or demanding times). In all, poor staff wellbeing, manifested in poor staff behaviours - such as "not being very nice", "being short", "not bothering", "not showing caring" - was attributed to either the overwhelming demands of the organisation or the job or to the limited capacity of individual staff members to manage reasonable workplace demands. Managers rarely noted the physical health consequences of 'heavy' workloads, either on individual staff, or on staff sickness rates within certain services. In addition, managers rarely mentioned the design and delivery of occupational health services as an

important resource for the ongoing support of staff. Occupational health, from the perspective of most managers, was a service that simply managed 'return to work' procedures or offered 'stress-management' for individuals. In all, the idea that "happy staff will make for happy patients" (Managing Director of Provider Services, informant 1.C2) was held by many interviewees. Only a few senior managers considered the longer-term value of a more coherent strategy to support staff wellbeing within their organisations.

Second, managers (sometimes in the same interview) held two distinctive perspectives on why staff wellbeing was important. From what we identify as a 'corporate perspective' managers were concerned with the consequences of poor staff wellbeing and patient care behaviour for the reputation of their organisation. Thus a Chief Executive noted that front-line care staff are "on stage all the time and they need to respond to that and to be caring" (informant 1.H2). From this corporate perspective, staff wellbeing was closely connected to staff engagement and working for the organisation. General managers sometimes noted how their own behaviour (that exemplified the organisation) influenced the "good performance", "good functioning" or "good feeling" of direct care staff situated further down the corporate order. A very different view of the purpose, antecedents and consequences of staff wellbeing was expressed by interviewees from what we identified as the 'vocational perspective'. This view, expressed more often by managers from a health professional backgrounds (n=30), was that staff wellbeing was rooted in the pleasures, satisfactions and frustrations of caring for patients. Interviewees talked of impoverished staff wellbeing – and the psychological stress and de-motivation expressed in poor interpersonal patient care behaviour - caused by ineffective management structures or inappropriate organisational demands (particularly performance management demands). These managers felt that organisational demands strained staff in their efforts to sustain good patient care in the face of increasing workloads and high patient 'throughput'. Thus one senior clinical manager observed, "I think [that] to ensure patient experience at a high level the staff has suffered...they've put their own wellbeing second for the sake of the patient.." (informant 7.H1).

Third, the interviews with managers found that without the capacity or incentive to consider the shorter and longer term implications of a coherent staff wellbeing strategy, most managers felt that the staff wellbeing agenda offered little new for staff, patients or their organisation. Managers did not consider the agenda to present a new perspective on ongoing operational concerns with staff motivation, affect and performance. Rather, they appropriated this agenda to reframe and justify longer standing views on the purpose and nature of health care work.

Summary

The interviews with managers to identify management perspectives on the relationship between staff wellbeing and patient experience showed that few managers considered staff wellbeing to be more than the immediate behaviour of staff in their interactions with patients. Staff wellbeing was

understood in two very different ways by managers: either as a factor that supported organisational objectives and reputation (a corporate view) or as the result of work satisfaction, particularly patient care work satisfaction, that was frustrated or undermined by organisational initiatives and demands (a vocational view). In either of these views it is clear that managers' appropriate the theme of 'staff wellbeing' to justify and push forward longer established views on the purpose and motives for health care work.

5.4 Summary of Phase I fieldwork

Our focus groups showed that patients' experience of their own, and others', direct care is vivid and can define an overall and very long term impression of an organisation, service or service area for years to come.

Looking across our four case study sites there were several contextual factors that were identified either by interviewees or through our documentary analysis as being important in shaping staff wellbeing and patient experience. We found innovative work relating to improving patient experience underway in each of the four sites using different technological approaches and/or organisational structures and systems. Typically, however there was less evidence across the four sites of 'leading-edge' initiatives aimed at improving staff wellbeing (compared to those seeking to improve patient experience), with the exception of a widely recognised and leading Health and Wellbeing programme at Elmwick.

The interviews with managers showed that staff wellbeing was understood in two very different ways: either as a factor that supported organisational objectives and reputation (a corporate view) or as the result of work satisfaction, particularly patient care work satisfaction, that was frustrated or undermined by organisational initiatives and demands (a vocational view). In both of these views it is clear that managers' appropriate the theme of 'staff wellbeing' to justify and push forward longer established views on the purpose and motives for health care work.

6 Phase II Fieldwork

6.1 Introduction

In this chapter we present details of the eight microsystems we studied. We also present the patient and staff survey descriptive data analysed by microsystem and finally these data sets combined together, examining links between staff and patient survey data. Table 13 summarises the data collection that was completed by (a) method and (b) microsystem.

Table 13. Data collection totals by clinical microsystem and by method

Clinical microsystem	Patient survey	Staff survey time 1	Staff survey time 2	Patient interviews	Staff interviews	Observation hours
1.1 EAU	690 (159) (23%)	119 (45)* (38%)	9	14	9	18
1.2 Maternity	580 (139) (24%)	134 (79) (59%)	53	13	10	22
2.1. M for E	111 (26) (23%)	192 (66) (34%)	23	13 ⁶ + 5 relatives	16	41
2.2. Haemato-oncology	245 (101) (41%)	77 (16) (34%)	10	13	10	13
3.1. ACNS (1)	37 (10) (27%)	125 (29) (23%)	0	11	12	17
3.2. CMS	19 (16) (84%)	14 (8) (57%)	6	11	8	33
4.1. ACNS (2)	57 (34) (59%)	32 (27) (84%)	14	12	9	37
4.2. RRT	40 (13) (32.5%)	49 (31) (63%)	11	14	12	25
TOTAL	1,779 (498) (28%)	742 (301) (40%)	301 (126) (42%)	106	86	206

⁶ We were able to access two patients post discharge and so supplemented the interviews with extra observation time, where we spoke informally to 11 more patients and five relatives as part of our fieldwork observations.

* Figures in brackets denote those included in final analysis from returns and are the staff survey questionnaires returned by front-line staff who give direct care to patients (so excludes ward clerks, administrators etc.)- see Appendix 19 for more detail.

First however, we present the eight microsystems where our case study research was undertaken.

6.2 Eight case study microsystems

The selection of the eight clinical microsystems followed the logic of identifying one high-performing and one low-performing microsystem (with respect to either or both staff wellbeing and patient experience) within each of the case study organisations. These were identified through interviews with senior managers in Phase I and, as outlined in Chapter 4, were also purposively sampled to include a range of patients groups with different disease trajectories and conditions requiring shorter or longer dwell time in the service (e.g. acute admissions, long term conditions in the community and cancer services) and anticipated different levels of emotional engagement and emotional labour (e.g. cancer; maternity services; elderly care). In summary (see Chapter 4 for details) selection of the two microsystems within each organisation was guided by the interviews with senior managers in Phase I, analysis of any routinely collected local or national data for potential microsystems, and the expressed consent of the clinical managers to participate in the research.

The microsystems identified in each of the case study sites are shown in Table 14 and each is described in turn further below.

Table 14. Clinical microsystems in study sites

	Perceived 'Low performing' microsystem	Perceived 'High performing' microsystem
Oakfield Acute Trust	Emergency Admissions Unit (EAU)	Maternity
Elmwick Acute Trust	Medicine for the Elderly (M for E)	Haematology
Ashcroft Community Trust	Adult Community Nursing Service (ACNS 1)	Community Matron Service (CMS)
Larchmere Community Trust	Rapid Response Team (RRS)	Adult Community and Palliative Home Care Nursing Service (ACNS 2)

6.2.1 Emergency Admissions Unit - Oakfield

Our first microsystem in our low performing Trust (Oakfield) was a combined medical and surgical assessment unit (the Emergency Admissions Unit [EAU]) which had opened in October 2005. The unit comprised 25 beds plus a dedicated assessment area with 11 assessment beds; patients whose predicted length of stay was likely to be between 24-72 hours were transferred to the co-located short stay ward with 2 female 8-bedded bays, a male 8-bedded bay and a side-room. We included this co-located short stay ward in our microsystem study. The microsystem comprised approximately 100 staff which included just under 18 full time equivalent experienced Band 6 nursing staff. Despite the urgent, short-stay needs of most attendees the Unit saw a small group of frequent attenders, typically patients with long-term substance abuse and/or mental health conditions.

Prior to our fieldwork beginning, in November-December 2008, the Trust had commissioned an external consultancy to carry out a major 'Staff Work and Wellbeing' survey which incorporated the Health & Safety Executive Stress (HSE) Risk Assessment Survey (and which became known by staff locally as the 'Stress Survey'). One of three identified hotspots within the Trust - 'where staff feel they're experiencing difficulties around stress and wellbeing' (Director of HR) - was the emergency directorate, which included the EAU. Particular issues from the survey that arose in this directorate were:

- Staff feeling that they have to work intensely and fast with different groups placing demands on them that are hard to combine. In addition, they feel they have to neglect some tasks because they have too much to do and are not able to take sufficient breaks.
- Staff feeling they are not getting supportive and encouraging feedback from their managers. There are also instances where staff do not feel supported through emotionally demanding work.

The detailed 'Staff Work and Wellbeing' survey findings from the EAU and from our other microsystem in this Trust, maternity services highlighted that 'urgent action' was required in the EAU in six of the seven HSE categories and there were 18 drivers for the below average performance that was reported; in contrast, there was no need for any 'urgent action' in the 'Women's & Children - Maternity' microsystem and only three drivers were identified. (It should be noted that only 21 staff from the EAU and 52 staff from 'Women & Children - maternity' responded to this survey; our own survey had higher numbers of respondents in both services). Further justification for selection of the EAU as a microsystem came from the medical director during our Phase I interviews:

"Because I think that there are stresses there, I think there's some real areas of stress on staff, both nursing and medical staff. You know, they're the high intensity nursing areas, the high intensity medical areas, it's where people cope with the workload for so long, but I'm not sure it's a long term area to work in particularly for nursing staff actually."

6.2.2 Maternity Service - Oakfield

Our second microsystem in Oakfield Trust was a maternity service which, although a consultant-led unit, saw 80% of cases being led by a midwife (and 40% of women looked after by midwives only). The service discharged approximately 200 mothers each month and was staffed by seven sisters and approximately 50 midwives. The service - housed in a poor physical environment - comprised a labour ward with four delivery rooms and four single rooms with adjoining toilet facilities, a shower room and a separate bathroom, and a birthing and a maternity ward with 30 postnatal beds (six 4-bed bays and six single rooms) with five toilets plus showers. In addition, the service had an ante-natal screening unit and a community midwife unit that was located at another site. The off-site community midwife service had opened in 1999 and faced some specific challenges in a relatively deprived, rural area but also enjoyed strong public support for the service which was based at a local hospital; it had five beds and delivered approximately 100 births a year in the unit and about 70 home births.

The maternity service was selected as a high-performing microsystem in Oakfield Trust. In the Care Quality Commission 2007 survey 89% of women surveyed said that their antenatal care was 'excellent', 'very good' or 'good', and 82% of women surveyed said that postnatal care they received was 'excellent', 'very good' or 'good'. The results of an internal Trust-wide 'Staff Work and Wellbeing' survey found that there was no need for any 'urgent action' in the 'Women's & Children - Maternity' service and only three drivers for below average performance were identified. Indeed, of the 65 'service areas' reported on in the survey results, 'Women's & Children - Maternity' was one of only 16 areas that did not require any 'urgent action'. Further justification for the selection of this service came from the Director of Estates and Facilities and the PPI manager during the Phase I interviews, respectively:

"Women's and Children's actually came out as some areas of very good practice. So we've actually got some examples of, I think that fits with many other things we've seen in the organisation, the Women and Children's is a, is different to other directorates in a number of ways, and I think that was confirmed in terms of the Work and Wellbeing survey too"

6.2.3 Medicine for the Elderly – Elmwick Acute Trust

The medicine for the elderly department was selected as a low performing service within our high performing Trust (Elmwick). It comprises four wards, two general elderly care wards (wards 2 and 4) one acute department for the elderly (ward 3) and a ward which was increasingly specialising in patients with delirium and dementia (ward 1), and moving to new accommodation to be a dedicated dementia and delirium unit in the near future. The wards were all similar in accommodation, with 27 beds, comprising four six -bedded bays and three side rooms. There was a programme of rotating refurbishment which meant wards were moving and re-locating during fieldwork in the spring and summer of 2010. There were two senior clinical nurses (one new in post) and six medical consultants plus

one locum consultant. Occupational therapists and physiotherapists, though reduced in number, were present in the wider team. Junior doctor cover was felt to be limited and inconsistent. On each ward there was a ward manager (band 7) and between four and six junior ward managers (band 6), with a team comprising registered nurses (band 5) and healthcare assistants (bands 2-3). We were directed to this service because of the perceived poor patient experience and a number of complaints from patients and relatives, which had together led to an organisational intervention focussed on patient experience improvement training for staff. Staff morale was thought to be very low and a distinct lack of team spirit was felt to be evident. The staffing establishment was thought to be at a low level, reflecting the rising demand of vulnerable patients, and there were recruitment and retention problems for the nursing team, with a large number of new staff joining over the last 12 months needing training for dementia and mental health nursing in general and, more generally, customer care training. The intervention with staff on the wards was undertaken six months before we commenced fieldwork and a number of recommendations had been - or were being - implemented whilst we undertook our study; senior staff in the service felt there had been some improvements.

6.2.4 Haematology Service – Elmwick Acute Trust

Our final acute microsystem was a haematology service selected as a high performer in Elmwick, comprising two in-patient wards and a day unit. The service is led by seven consultants. One of the wards (Haematology and Bone Marrow Transplant ward) cares for people undergoing investigations and treatment of disorders affecting the blood or bone marrow. This long-established ward has 16 beds (11 single, one 3-bedded bay and one 2-bedded bay) and every room has en-suite facilities. The ward was staffed by a ward registrar, senior house officer and house officer; nursing staff includes a senior sister, junior sisters, senior staff nurses, health care assistants and physicians assistant and there is also a ward receptionist, ward assistants and housekeepers. This ward was able to treat patients who were having bone marrow transplants from donors who were not related to them (as it could provide positive air pressure in the patient rooms to reduce the risk of infections). The second in-patient ward could not treat such patients and had opened some two years prior to our fieldwork with similar staffing and 11 beds in a mix of single rooms and small bays. Other staff who attend to patients on both in-patient wards include physiotherapists, dieticians, specialist nurses and Macmillan nurses. Finally, the service comprised a haematology day unit where patients receive their treatment and care (often chemotherapy) on an outpatient basis; many patients will have already received inpatient treatment on one of the inpatient wards but will continue to require treatment or review in the day unit following their discharge.

Towards the end of our fieldwork it was announced that the second in-patient ward was to close and the existing day unit would relocate to this ward. This meant that all the staff on the ward would be redeployed to

other wards or services within the oncology directorate. The day unit would be expanded and its opening times increased to Monday to Sunday 8:00-20:00 (compared to Monday to Saturday and on Saturdays only until 16:00). The existing day unit facility was to become a cancer assessment unit run by Band 7 and Band 6 nurses. The overall aim of these changes was to move significantly to a more outpatients-based service as was happening in other areas of the country. The changes - which were implemented just as our fieldwork concluded - had a significant negative effect on staff morale on the second in-patient ward; many staff in all areas of the service expressed concern as to whether the reduced bed capacity would have a serious negative effect on their ability to meet rising demands if the planned expansion of outpatient and day care facilities was inadequate (as many of them suspected they would be). These are important contextual factors that may have contributed to the somewhat surprising survey findings relating to affective patient orientation and job skills.

6.2.5 Acute Community Nursing Service 1 – Ashcroft Community Trust

In 2010 the day service comprised 13 teams organised in six locality clusters managed by five cluster matrons. This service, operating between 8.30 and 5.00pm, was aligned to an 'out of hours team' that covered essential evening care for all clusters between 6pm and 11pm. In addition, a limited night service team (of one qualified nurse and one or two health care assistants) covered essential and emergency community nursing cover across the former PCT boundaries. In all the service employed 125 nurses on fulltime or part-time contracts or through nurse bank arrangements. However some scrutiny of these staff lists indicated that at least 20% of these staff were employed as both full-time day staff (often in senior team leadership positions) and as evening bank staff. In 2009/10 the staff vacancy rate was very high (various service managers and the organisation were disputing rates of between 19%, 23% and 35%)⁷. Managers explained that the reasons for employing permanent day staff as evening bank staff was to both overcome staff shortages and ensure some continuity of care between the day and evening service. However field observations suggested that several of these staff were working a 14 hour day on a regular (and at least weekly) basis.

This service was recommended to the research team by all managers in Ashcroft who noted that it had a long standing and poor reputation for patient safety and patient care performance. Managers and senior clinicians also described, often in vivid detail, events of unsafe practice and very poor patient or family care, only some of which had resulted in formal complaint investigations within the organisation. In addition, managers noted enduring problems of staff recruitment and retention in the service and the resulting stains on staff wellbeing. They described the situation of current

⁷ Service and organisational performance reports in 2008/9 indicate an overspend in this service of over £200,000 pa on agency staff nurse costs.

staff as being “not in a happy place” (Head of Patient Safety and Patient Experience); “stressed” (Head of Service), “stretched (Nurse Consultant) and “disillusioned” (Nurse Consultant). The Director of Provider Services noted the long standing difficulties of engaging “apathetic staff”. They also observed the negative effects of ongoing service and organisational reforms following the Transforming Community Services (TCS) agenda and described the increasing feelings of distrust amongst staff towards the organisation. This Director, and several senior clinical staff who had been involved in improving patient care in this service for several years, also noted a recent upturn in the quality of clinical care and staff wellbeing following the most recent service realignments (most notably the appointment of five community matrons to oversee the community nursing teams).

6.2.6 Community Matron Service - Ashcroft Community Trust

This specialist community matron service which provided intensive nursing support for adult community patients with the most complex medical and social need within the former PCT was recommended to the research team by the Director of Community Health Provider Services. In this role, as well as in a former PCT role as Director of Quality (Nursing and Allied Professions) they had pioneered this service and championed it within and beyond the organisation. The Director felt that this high quality community nursing service represented the organisation in the most positive light.

In 2010 the key elements of this specialist service were nine or ten ‘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 their 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. This system, operated by five 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 two 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 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).

6.2.7 Adult Community Nursing Service 2 – Larchmere Community Trust

This microsystem, one of four localities of an Adult Community Nursing and Palliative Care Service, comprised five teams of qualified nursing staff and health care assistants. The service delivered home-based patient assessment and clinical care, including palliative and end-of-life care, and clinic-based general or specialist nursing care. The locality service, with a total of 29 staff (of these four were part time and three were unqualified) operates from 8.00 am to 7.00 pm, Monday to Friday, with internal rotation of Band 6 staff to deliver a more limited weekend service (for essential medication support or admissions and for 'end of life' care) across the locality. Later evening and night time home nursing care is provided by the 'Out of Hours' Adult Community Nursing and Palliative Care team who include some part time members of the day service working to a different immediate manager. During day time shifts the majority of staff (qualified and unqualified) visit between five and eight patients in the morning and a further two to four patients in the afternoon. It was not unusual for staff to spend 45 minutes on a round trip to a patient in an outlying rural area. Qualified staff also rotated through specialist community nurse clinics held for more mobile patients with specific clinical needs.

With the exception of one member of staff (on booked, long term sick leave) and maternity leave staff absence in the service locality was rare. In addition, staff retention rates in the service were high, with the longest serving staff (qualified) having worked in the same teams for over a decade and with staff who had worked in the service for two years or more being referred to as 'still quite new'. In the service locality that comprised the clinical microsystem over one third of staff had worked here for over 16 years. These locality teams are also notable for their mix of younger and older newer qualified staff. More junior older staff ('return to practice' recruits and former skilled factor employees) were especially vocal about their enjoyment of their work in direct patient care.

Patients arrive into the service through a variety of adjacent services (GPs; hospital discharge co-ordinators; specialist health and community services) and, with no single point of referral, Band 6 responsibility extends to regular and direct negotiation with staff in these other services and the management of an unpredictable patient case load. These management demands were eased by effective co-working between Band 6s who shared

office space and, in one case junior qualified staff and often worked to even out changing work demands on their teams. Ongoing service liaison with GPs, social services or specialist community services occurred either 'as required' (for an individual patient) or, in some practices, through regular GP-led care review meetings to which nurse representatives were invited (and less often contributed). The occurrence and frequency of GP-led patient review meetings varies from GP practice to GP practice, and community nursing staff considered themselves fortunate if they were working with GP practices that held regular and well attended patient review meetings.

6.2.8 Rapid Response Service – Larchmere Community Trust

The Head of Adult Community Nursing Services in Larchmere organisation recommended the researchers to this Rapid Response Service (RRS), a residential or nursing home and domiciliary rehabilitation service. This manager felt that staff wellbeing was poor and had dealt with a series of informal and formal patient complaints about this service (including a CQC investigation over professional negligence). In addition this manager was dealing with a series of complaints about the service from staff in other services within and outside of Larchmere. Reports of poor patient care and patient safety, as well as of poor inter-service or inter-organisational working by this service, had also recently become a concern for senior organisational managers and service commissioners.

The RRS was unusual in its design, if not in its holistic vision of patient care and rehabilitation. The RRS, established three years previously, was a joint-funded (local authority/former PCT) and interdisciplinary rehabilitation service. The service was 'Rapid Response' because it provided holistic patient assessment within 24 hours of patient referral into the service. Referrals were taken directly by qualified staff in the RRT from a variety of health and social service settings. These included acute hospital services (principally 'discharge' or 'rehabilitation' hospital units); other community services (such as adult community nursing services); primary care professionals and, less often adult social services. The RSS operated 12 hours a day, seven days a week and served the former PCT and local authority population. It employed ten unqualified care and rehabilitation assistants (50% under local authority contract and 50% under health service contact) who worked together under a team leader employed by the local authority. These staff worked separately to, but often overlapped and exchanged patient information with, a multi-disciplinary team of qualified staff (16) supported by practice assistants (six). Senior members of this team were responsible for holistic patient assessment and more junior members of the team monitored and reviewed the progress of patient rehabilitation care planning in a range of residential, nursing home and domiciliary settings across the former PCT. Patient care was provided on admission to one of 50 rehabilitation beds (located in separate areas of two nursing homes and two residential homes in different geographical areas of the local authority/former PCT). Depending on the various contract arrangements in different residential or nursing home facilities patients

received personal and/or nursing care from staff employed in these homes and their rehabilitation care from assistants employed by the RRS. These assistants worked with patients in the residential or nursing homes once or twice a day often alongside professional RRS staff. The service also provided rehabilitation support for up to 21 domiciliary patients/service users from across the former PCT area. During the research period up to 11 patients were receiving RRS care assistant home visits to meet rehabilitation or personal care needs.

6.3 Patient survey

As outlined in Chapter 4 and Appendix 14, we developed a 48 item questionnaire which used the Patient Evaluation of Emotional Care During Hospitalisation (PEECH) tool (330) to capture the relational aspects of care and the short-form Picker (323) to capture functional or transactional aspects of care.

We undertook an exploratory factor analysis of the PEECH items (see Appendix 15) and although a different structure to the original instrument emerged, we advocate that researchers continue to use Williams and Kristjanson structure in the UK until further testing in a wider range of settings has taken place.

Overall we received 498 completed surveys (28% response rate) with variation across microsystems (see Table 11- Data collection totals by clinical microsystem and by method). Appendix 19 gives full details of the profile of the patients who completed the survey across the eight microsystems.

6.4 Patient survey descriptive results

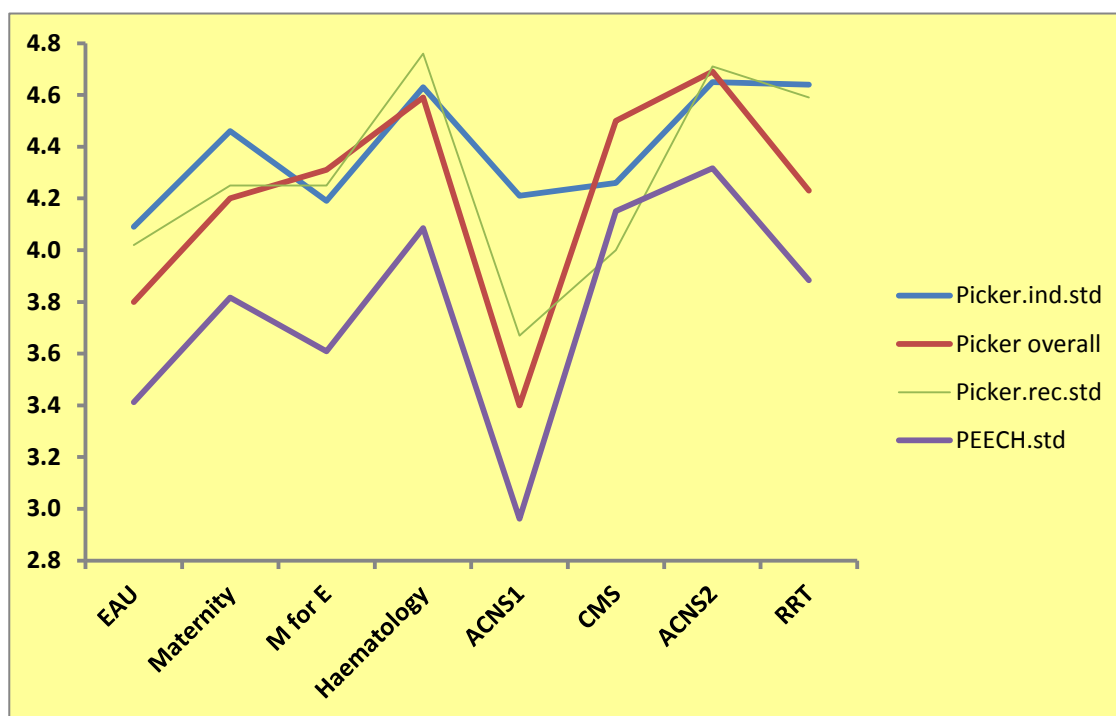
6.4.1 Patient sample profile

The age profile of our respondents reflected a very wide range; with over 20% of our patients under 30 and 20% over 80. The age profile of patients was older for community microsystems and for medicine for the elderly. As expected maternity patients were the youngest. The majority (69%) were women, and men were in the minority across all microsystems except haematology where they represented 55% of respondents. Apart from Maternity the highest proportion of females was found amongst patients seen by the rapid response team. This microsystem also had the oldest patient profile. Half our respondents (50%) rated their health as good or very good. Maternity patients not surprisingly rated their health more highly than patients in any other microsystem and were least likely to have long term conditions. The Community Matron Service provided care to patients who were in the poorest health. Many of the patients (80% or higher) seen by the community microsystems and haematology had long-term conditions and with medicine for the elderly were unsurprisingly experiencing difficulties due to these conditions.

6.4.2 PEECH and Picker measures of patient experience

Here we present the patient survey results from the PEECH and Picker measures of patient experience. Figure 7 shows mean scores standardised to a five-point scale for PEECH and three Picker measures; the Picker Index (PPE-15), overall impression and would the patient recommend the service (microsystem) to friends and family. PEECH and Picker Overall track each other quite closely and suggesting that they are tapping into similar aspects of patient experience. The Picker Index displays less variability and Picker has elements of the three other measures. The first adult community nursing service is clearly doing less well in terms of patient experience than the other microsystems. Amongst the acute microsystems maternity and haematology performed better according to these measures than the emergency admissions unit or medicine for the elderly.

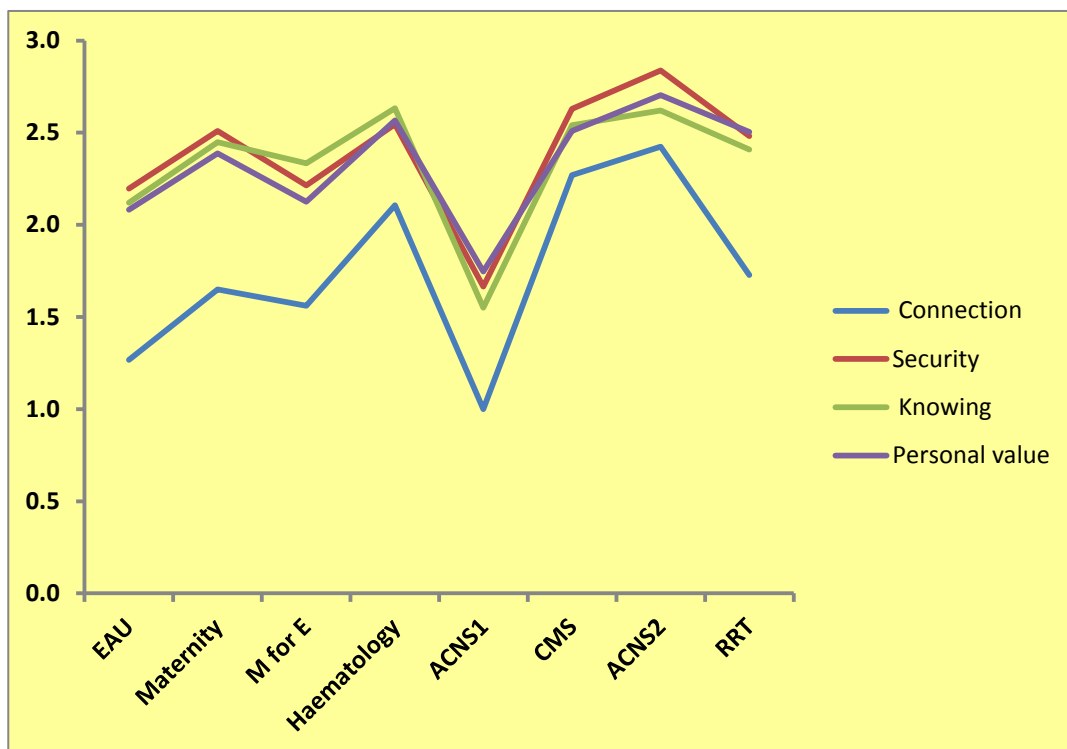
Figure 7. PEECH and Picker measure of patient experience



*all variables that include 'std' in the label have been standardised to a 1-5 scale (Picker index 0-15, Picker recommendation 1-4, PEECH 0-3) on the vertical axis

In Figure 8 data from PEECH is broken down into its individual components to ascertain whether a consistent picture emerges or whether microsystems do better on some components rather than others.

Figure 8. Components of PEECH across microsystems



All four PEECH components track each other closely (Figure 8 and 9) with the low performing microsystems (EAU; Medicine for the elderly ACNS1 and RRT) performing the worst. All microsystems perform less well on level of connection. This suggests, that particularly in the low performing systems staff are not creating meaningful relationships with patients – not getting to know patients as individuals/as people. There is little to separate the three other components. As in Figure 6 the first adult community nursing service performs less well overall than the other microsystems. The separation between that service and the other microsystems is at its greatest for level of security and level of knowing. With one exception patients cared for in the community microsystems observed higher levels of emotional care than their acute counterparts. The profiles for three of the community microsystems are similar except on level of connection where the rapid response team does less well. Haematology was the acute microsystem with the highest scores on PEECH and the emergency admissions unit the lowest although this service did match medicine for the elderly on level of security and level of personal value.

Figure 9. Overall PEECH across microsystems

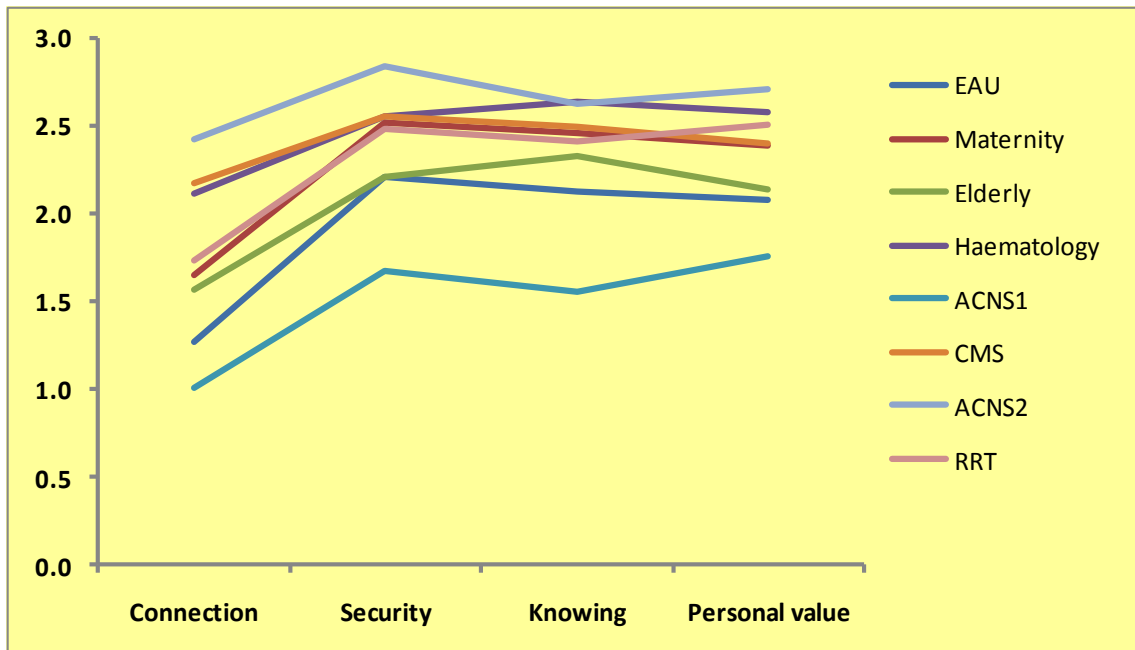


Figure 9 illustrates the four PEECH levels by microsystem in a different way, helping to illustrate that ACNS1 and EAU are the lowest performing across all four levels and ACNS2 and haematology the highest. Appendix 20 illustrates the four levels across all eight microsystems with confidence intervals.

We now examine results from the Picker questions that were not part of the short-form instrument that gauge patient experience in relation to: courtesy, respect and dignity; confidence and trust; nurse staffing levels; involvement in care; help with meals/general health; how well doctors and nurses work together; wanting to complain; rating of care received; willingness to recommend the service to family and friends.

Figure 10. Overall, did you feel you were treated with respect and dignity while you were in hospital – service?

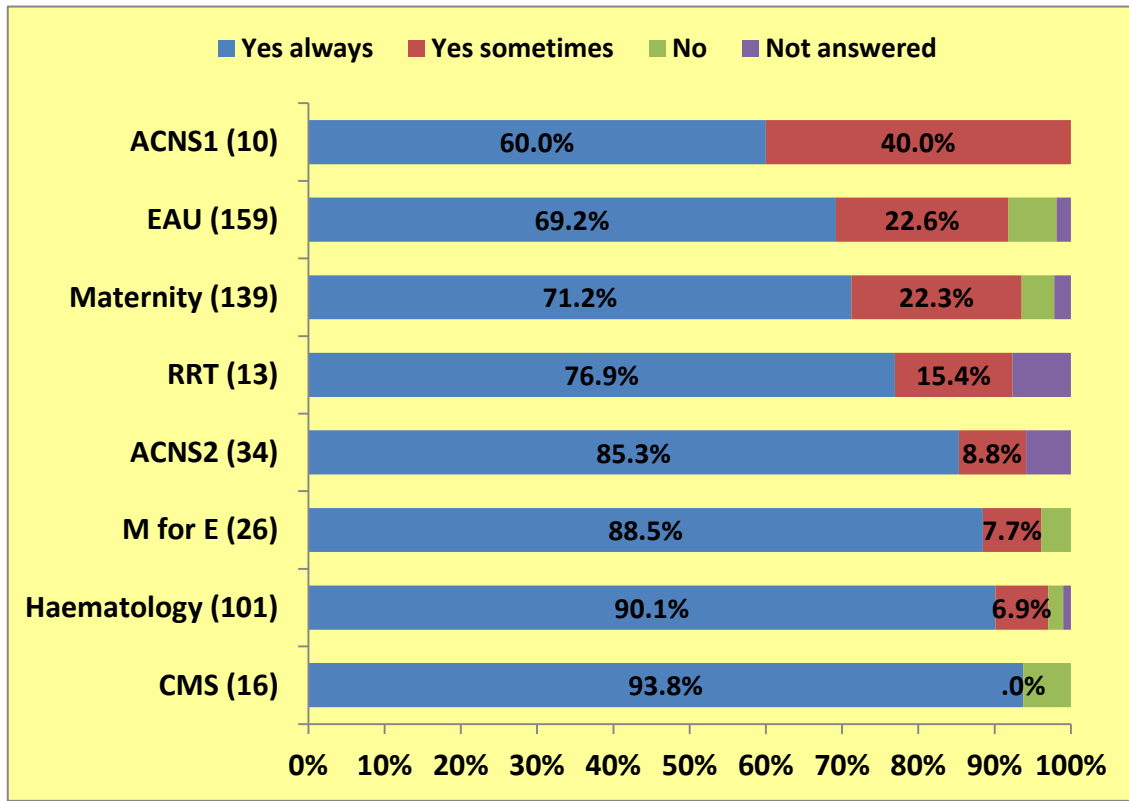


Figure 10 continues to support the results from the PEECH suggesting ACNS1 and EAU are rated least favourably but here it is the community matron service and Haematology (not ACNS2), that are rated the most favourably in terms of dignity and respect.

The following three Figures look specifically at courtesy and respect whilst in the care of the hospital or the service.

Figure 11. I felt the nurses/midwives/staff treated me with courtesy and respect whilst I was in hospital/in their care

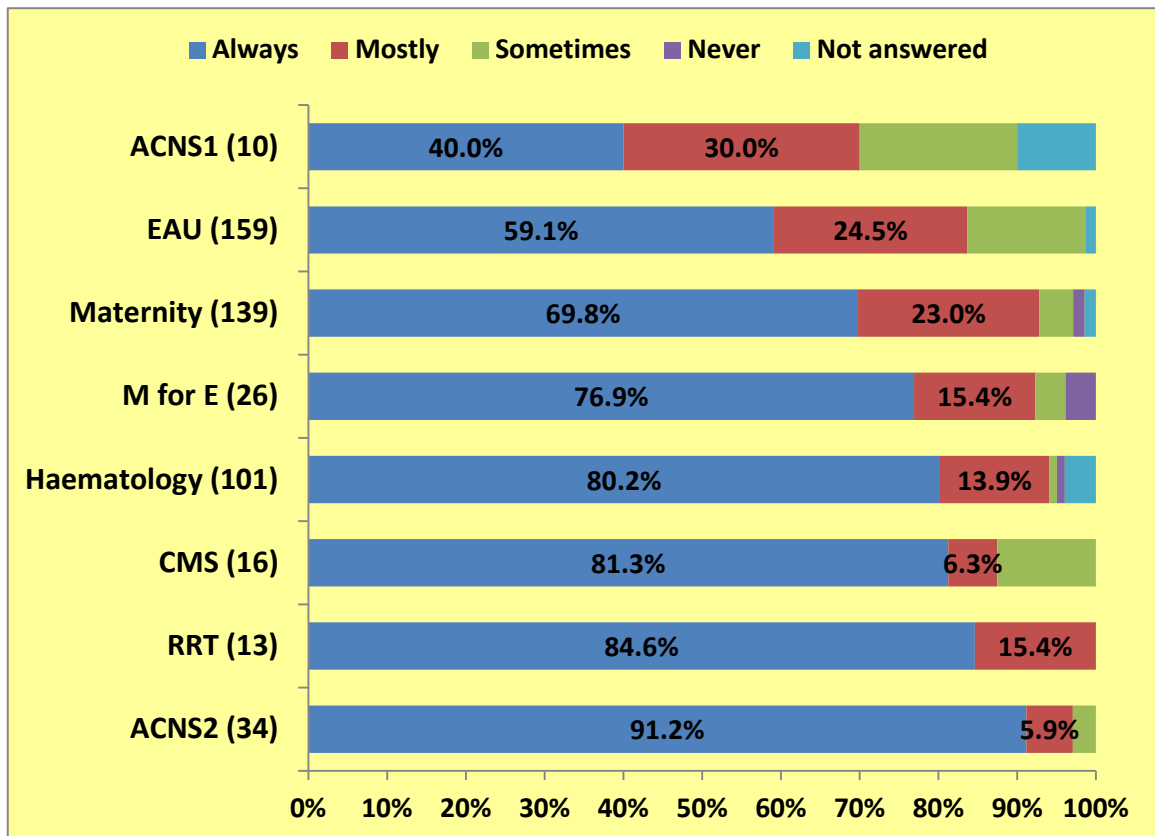
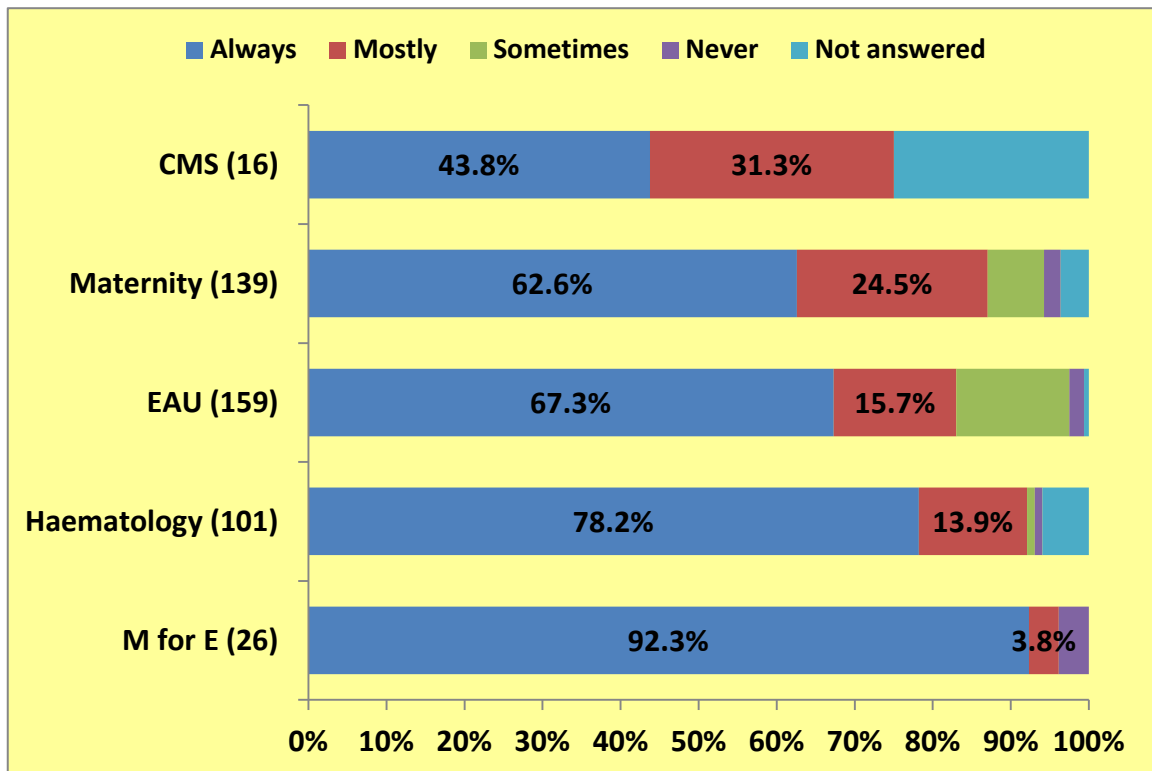
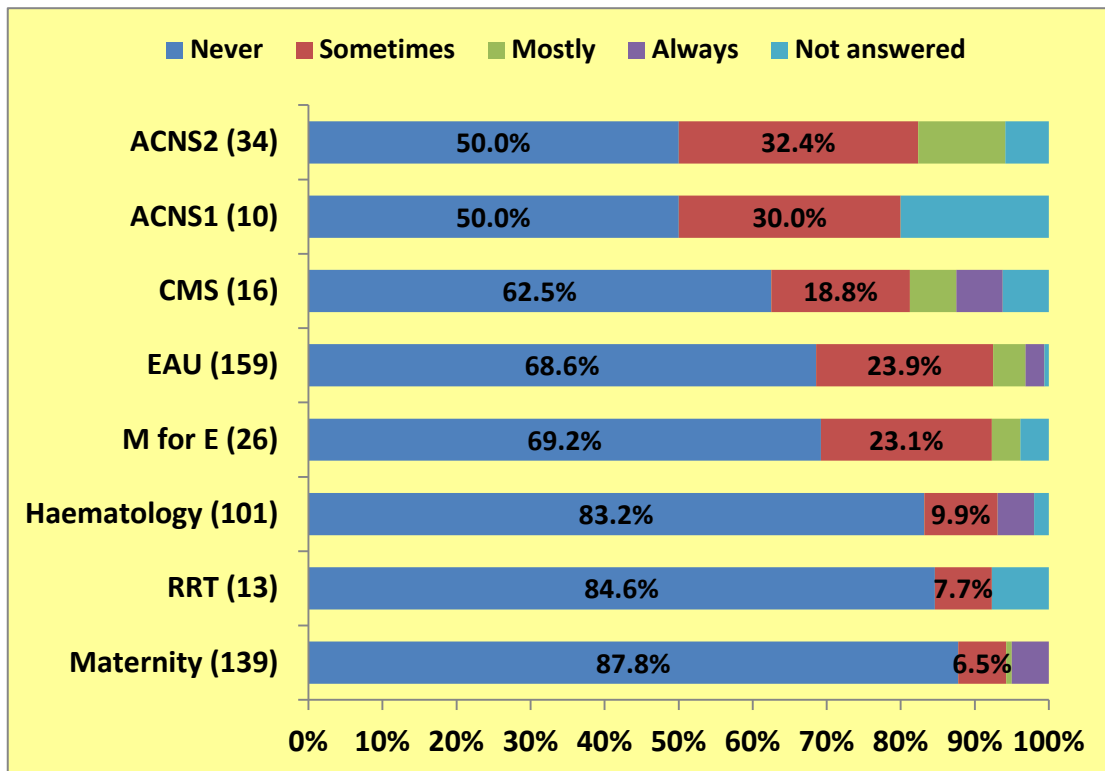


Figure 12. I felt the doctors treated me with courtesy and respect whilst I was in hospital/in their care



Higher levels of courtesy and respect were reported by patients in the community settings, compared with acute settings, except for ACNS1. The equivalent question relating to doctors was confined to acute care settings and the community matron service. Courtesy and respect was the lowest in CMS. Midwives working in maternity service were more likely to treat patients with courtesy and respect than doctors; the reverse was found in EAU and Medicine for the Elderly. The level of courtesy and respect accorded to patients was at its highest amongst doctors in Medicine for the Elderly followed closely by nurses working in ACNS2.

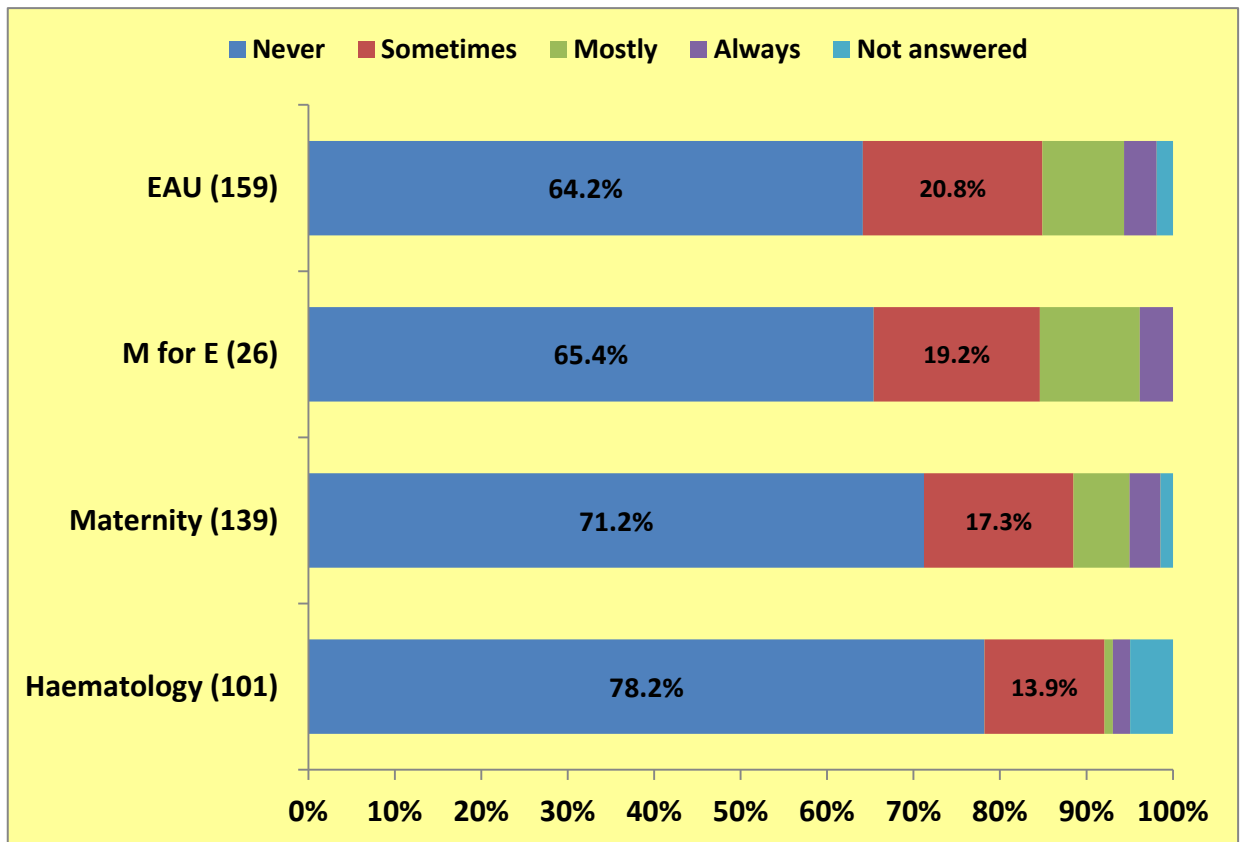
Figure 13. Did nurses/midwives/staff talk in front of you, as if you weren't there?



Nurses/staff employed in the community settings, apart for RRT, were more likely to talk in front of patients than in acute settings.

CMS patients were asked separate questions about treatment of their relatives/carer and home by staff. In both cases a high percentage (always or mostly) of patients' felt staff had treated their relative/carer (88%) and home (94%) with courtesy and respect.

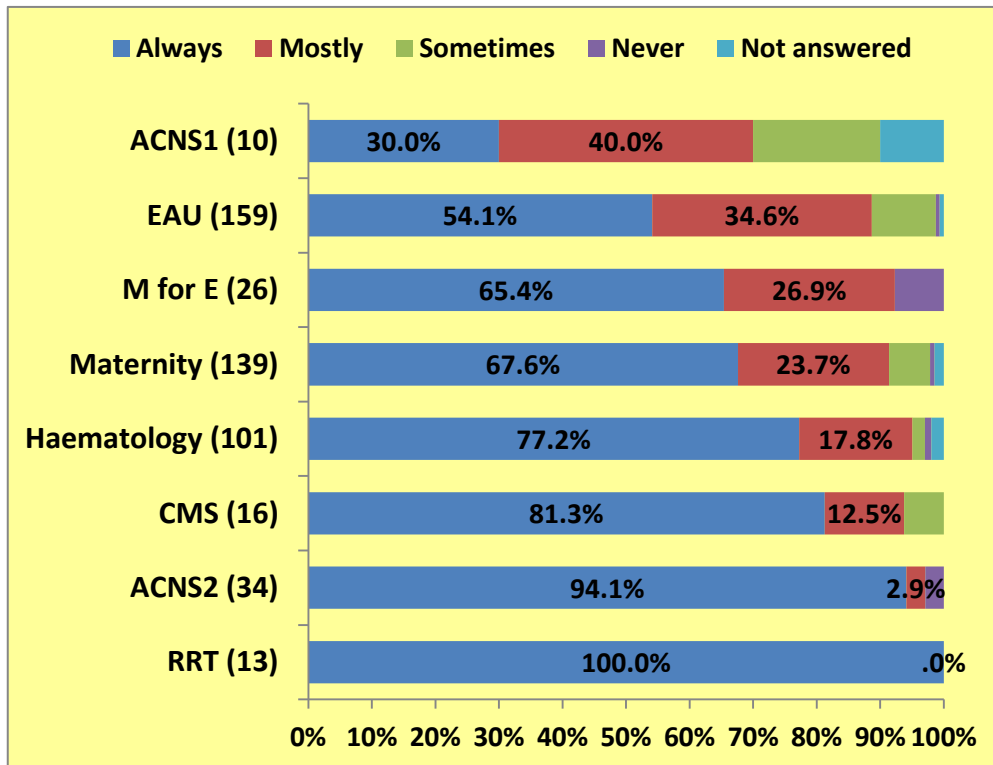
Figure 14. Did doctors talk in front of you, as if you weren't there?



A similar pattern to that seen amongst nurses/midwives/staff emerges although doctors in the maternity service do less well than their midwifery colleagues. Patients in CMS were asked a separate question about whether staff treated their home with respect and over 80% stated 'always'.

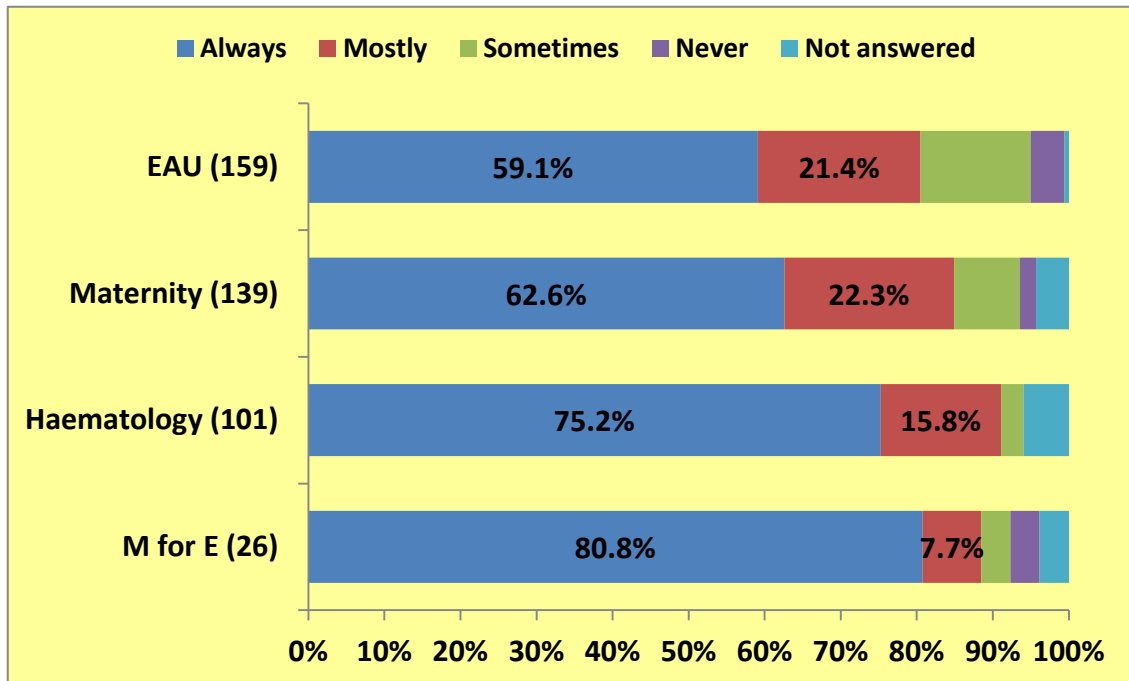
The next two Figures present data on confidence and trust of nurses/midwives/staff (Figure 15) and doctors (Figure 16).

Figure 15. Did you have confidence and trust in the nurses/midwives/staff treating you?



It was in the community microsystems where patients had greatest confidence and trust, apart from ACNS1 where patients had the least confidence. Haematology was the best performing acute microsystem on this measure.

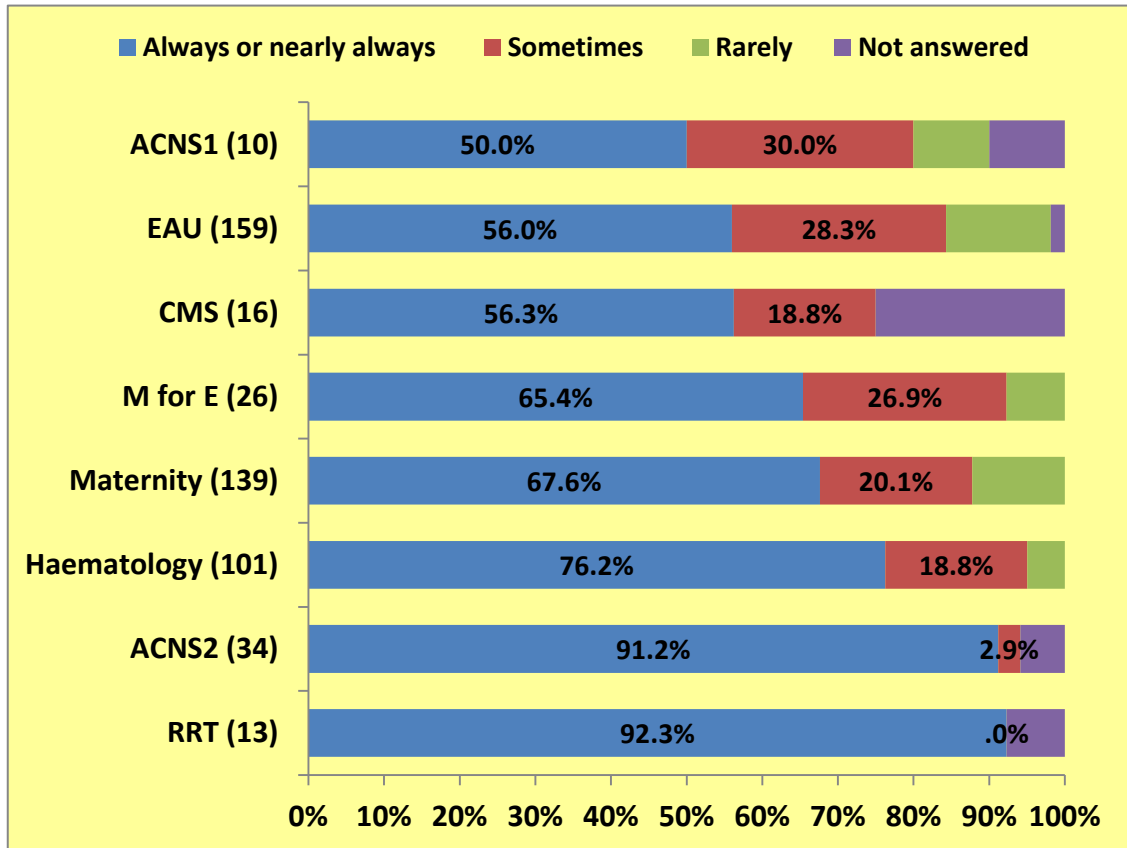
Figure 16. Did you have confidence and trust in the doctors treating you?



Doctors working in Medicine for the Elderly were rated highest by patients in terms of trust and confidence in the four acute microsystems. Patients had greater trust and confidence in doctors compared to nurses in Medicine for the Elderly. Both doctors and nurses working in Haematology performed consistently well on this measure.

Figure 17 shows patient views on the level of nurse staffing.

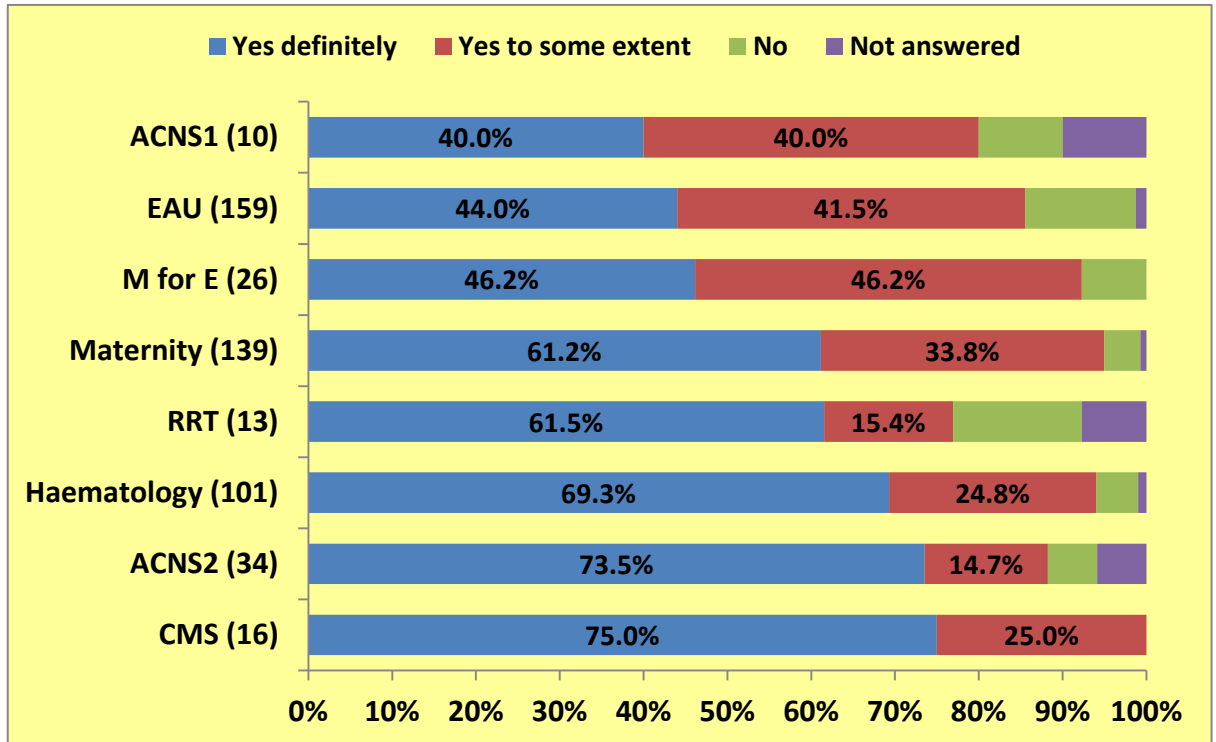
Figure 17. In your opinion were there enough nurses/midwives/staff on duty to care for you?



There were always, or nearly always enough staff working in RRT and ACNS2 but for ACNS1, EAU and CMS the percentage of patients sharing this opinion was much lower at around a half.

The next Picker question asked patients about their involvement in decisions about their care and treatment (Figure 18).

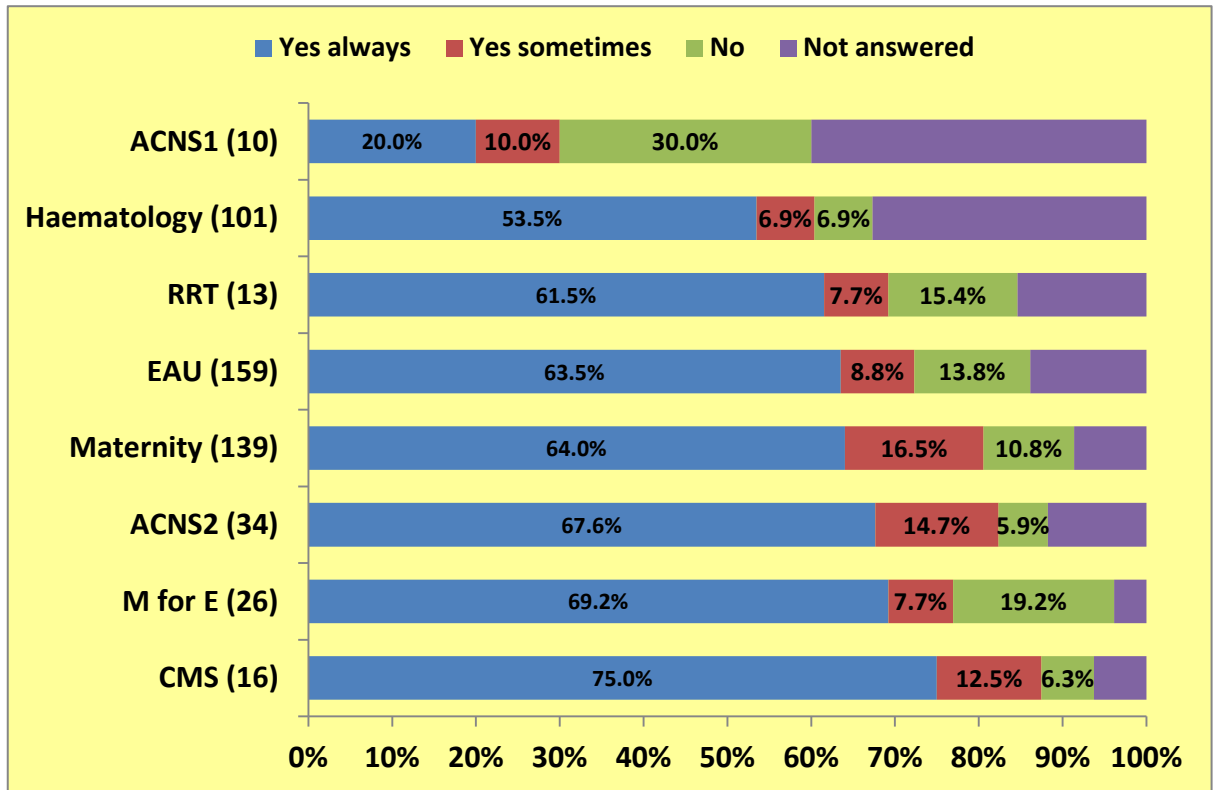
Figure 18. Were you involved as much as you wanted to be in decisions about your care and treatment?



Four-fifths or more of patients were involved in decisions about their care but the degree of perceived involvement varied considerably across microsystems. Patients were most involved in CMS and least involved in ACNS1, EAU and Medicine for the Elderly.

Patients' were asked whether they received all the help they needed with eating meals in hospital or with their general health when receiving care in community settings (Figure 19).

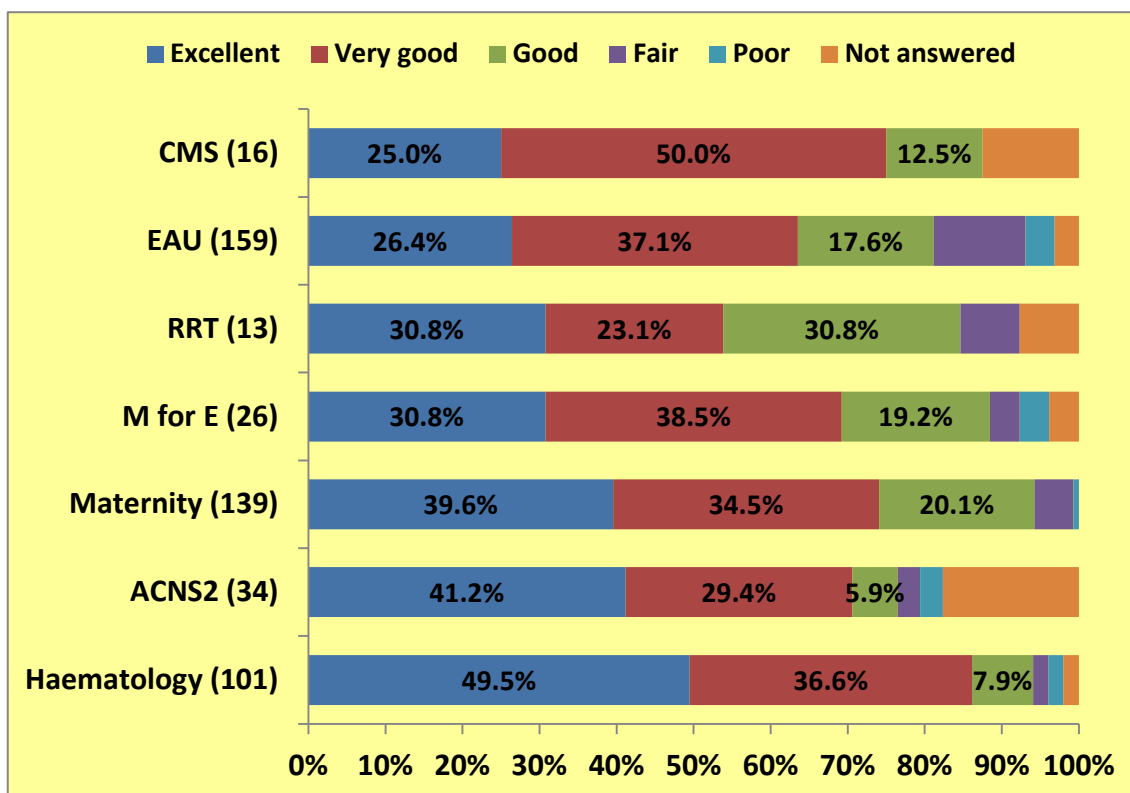
Figure 19. I had all the help I needed from staff to eat my meals (acute settings) or with my general health (community settings)



Patients in Medicine for the Elderly received help most often with eating meals in acute settings. In terms of general health CMS staff provided help most often and ACNS1 staff least often.

Patients were given an opportunity to rate how well different groups of staff worked together (Figure 20).

Figure 20. How would you rate how well the doctors and healthcare team (nurses /midwives/staff) worked together?



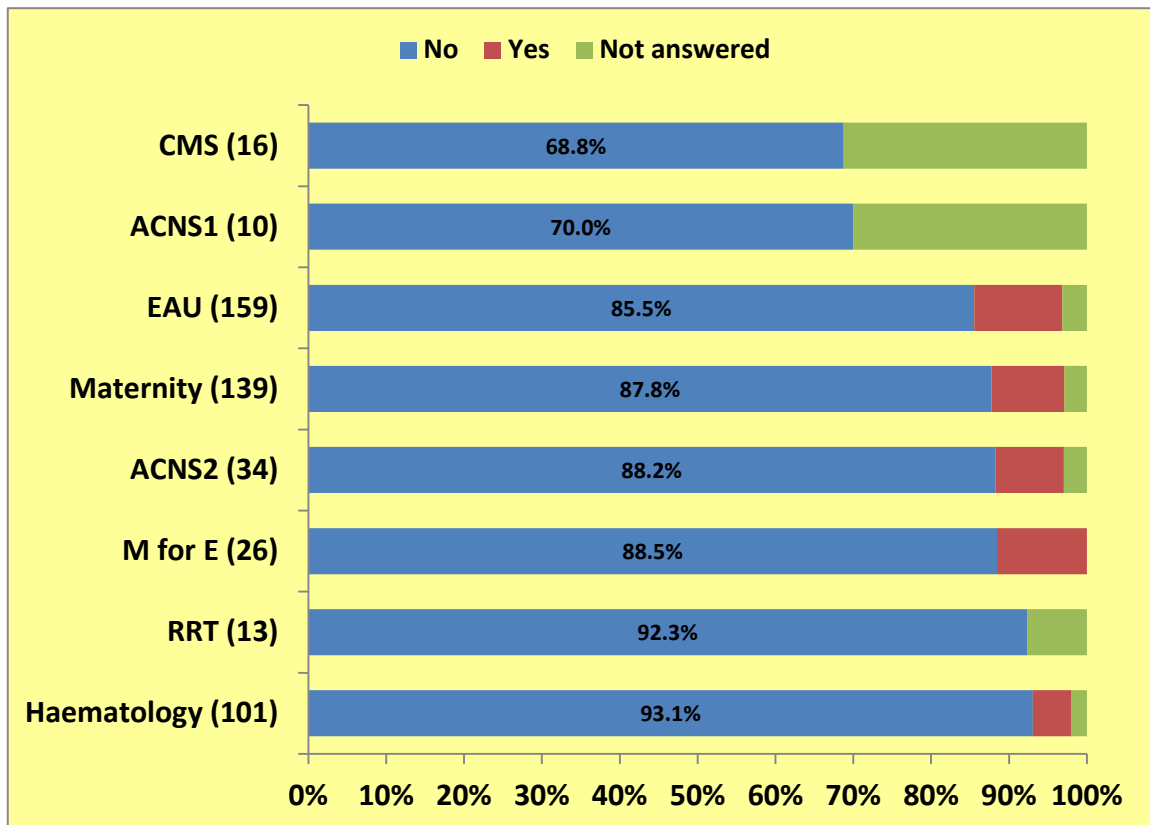
¹ this question was not answered by patients in ACNS1

Three-quarters or more of patients thought doctors and the healthcare team worked well together. The percentage of patients who were prepared to give the highest rating of excellent varied from 25% in CMS up to almost 50% Haematology.

Patients thought doctors and the healthcare team worked best together in Haematology, but scores were lower in CMS and EAU.

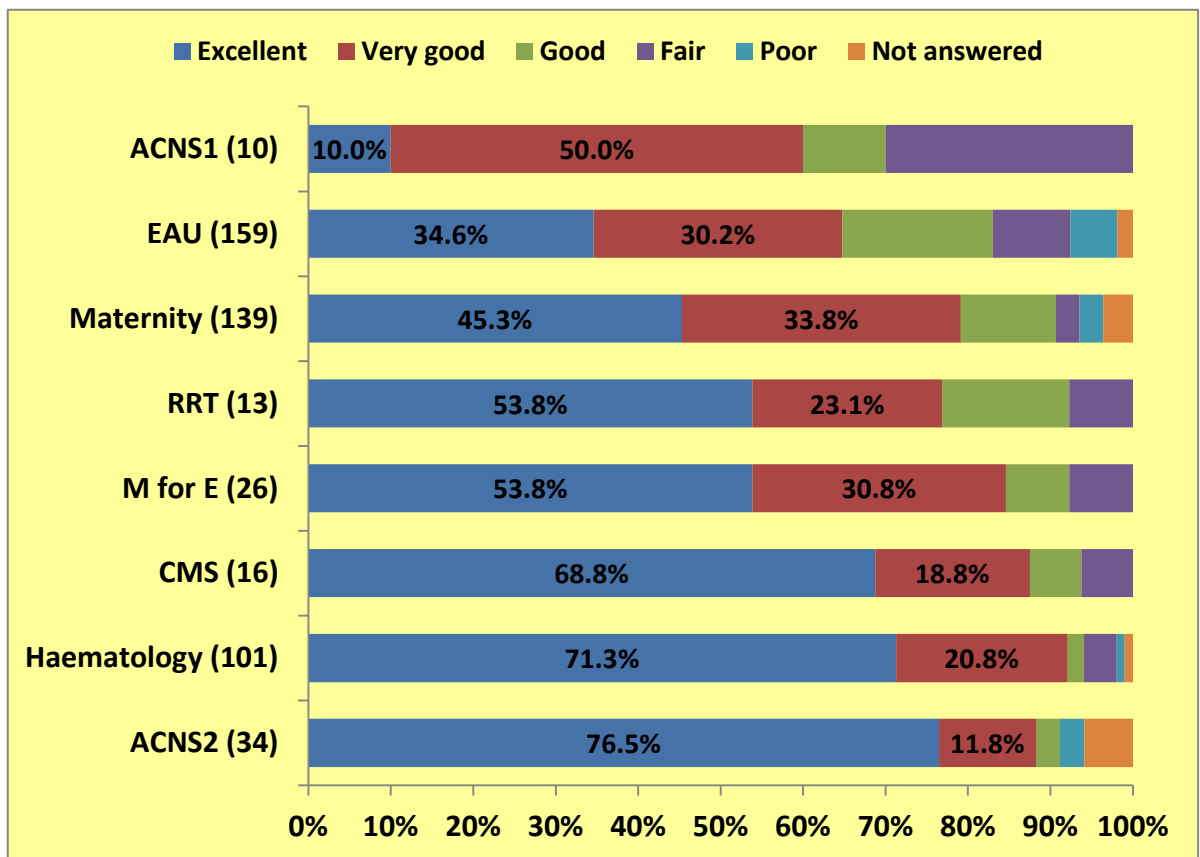
Patients' were asked about whether they wanted to complain about the care they received (Figure 21).

Figure 21. Did you want to complain about the care you received in hospital?



Patients were least likely to have wanted to complain about their care in Haematology. A desire not to complain was generally high across all microsystems except for CMS and ACNS1 where about 30% of patients wanted to complain.

Figure 22. Overall how do you rate the care you received?



Sixty percent or more of the patients rated the care they received as either excellent or very good (Figure 22). There was considerable variation in the percentage of patients prepared to give the highest rating of excellent to a microsystem ranging from 10% in ACNS1 to 76% in ACNS2. Both haematology (71%) and CMS (69%) also performed well on this measure.

Figure 23. Overall “would you recommend this hospital-service to your friends and family?”

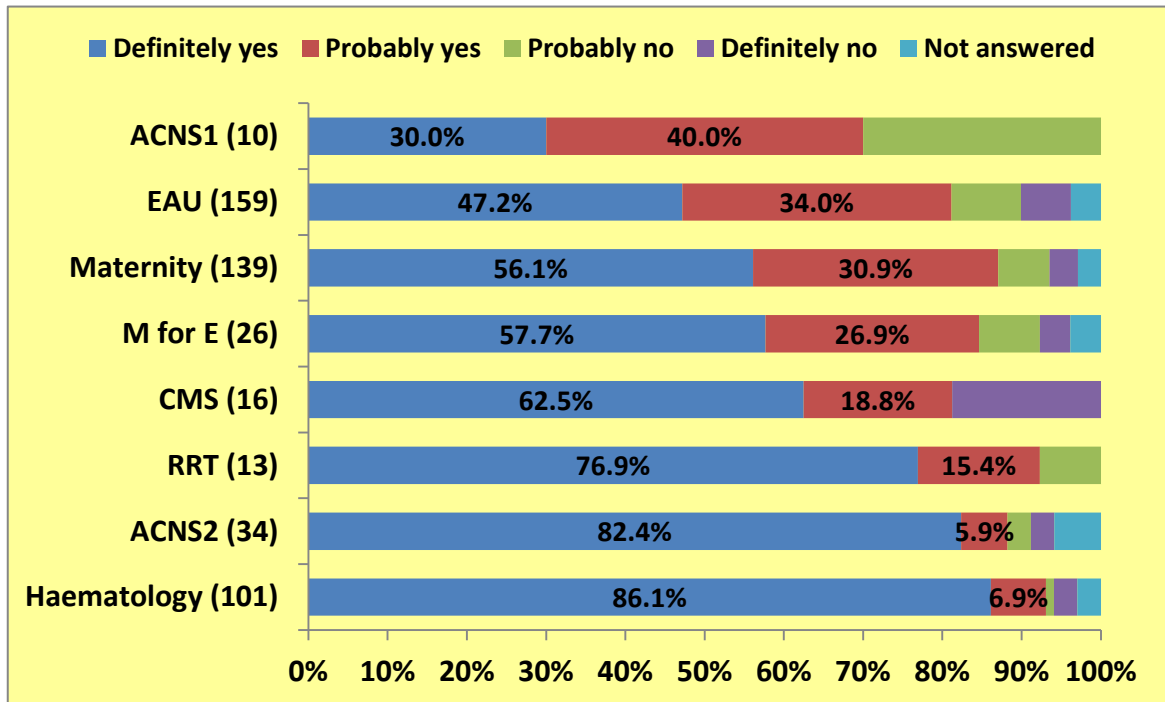


Figure 23 presents data from the question asking patients whether they would recommend the hospital/service to their family and friends. Seventy percent or more patients would definitely or probably recommend a microsystem to friends and family. The percentage of patients who would definitely make a recommendation varied from 30% in ACNS1 to 86% in Haematology. Both ACNS2 (82%) and RRT (77%) also did well on this measure.

Table 15 summarises the results from Figures 10 to 23. It is clear from this summary that both ACNS2 and Haematology were the best performing microsystems on these Picker patient experience measures. ACNS1 and EAU fared less well overall when compared against the other microsystems.

Table 15. Summary of individual Picker items across microsystems that are not part of the short-form (PPE-15)

		EAU		Maternity		M for E		Haematology		ACNS1		CMS		ACNS2		RRT	
		%	(rank)	%	(rank)	%	(rank)	%	(rank)	%	(rank)	%	(rank)	%	(rank)	%	(rank)
Respect, dignity and courtesy																	
Overall did you feel you were treated with respect and dignity while you were in the hospital-service?	Yes always	69.2	(7)	71.2	(6)	88.5	(3)	90.1	(2)	60.0	(8)	93.8	(1)	85.3	(4)	76.9	(5)
I felt the nurses treated me with courtesy and respect whilst I was in hospital/in their care	Always	59.0	(7)	69.8	(6)	76.9	(5)	80.2	(4)	40.0	(8)	81.3	(3)	91.2	(1)	84.6	(2)
I felt the doctors treated me with courtesy and respect whilst I was in hospital-service	Always	67.3	(3)	62.6	(4)	92.3	(1)	78.2	(2)	n/a		43.8	(5)	n/a		n/a	
Did nurses/staff talk in front of you as if you weren't their?	Never	68.6	(5)	87.8	(1)	69.2	(4)	83.2	(3)	50.0	(7)	62.5	(6)	50.0	(8)	84.6	(2)
Did doctors talk in front of you as if you weren't their?	Never	64.2	(4)	71.2	(2)	65.4	(3)	78.2	(1)	n/a		n/a		n/a		n/a	
Confience and trust																	
Did you have confidence and trust in nurses/staff treating you?	Always	54.1	(7)	67.6	(5)	65.4	(6)	77.2	(4)	30.0	(8)	81.3	(3)	94.1	(2)	100.0	(1)
Did you have confidence and trust in doctors treating you?	Always	59.1	(5)	62.6	(4)	80.8	(1)	75.2	(2)					n/a		n/a	
Staffing levels/working together																	
In your opinion were there enough nurses/staff on duty to care for you?	Always or nearly always	56.0	(7)	67.6	(4)	65.4	(5)	76.2	(3)	50.0	(8)	56.3	(6)	91.2	(2)	92.3	(1)
How would you rate how well doctors, nurses/other staff and their team worked together	Excellent/Very Good	63.5	(6)	74.1	(3)	69.2	(5)	86.1	(1)	n/a		75.0	(2)	70.6	(4)	53.8	(7)
Involvement in care and treatment																	
Were you involved as much as you wanted to be in the decisions about your care and treatment?	Yes defintely	44.0	(7)	61.2	(5)	46.2	(6)	69.3	(3)	40.0	(8)	75.0	(1)	73.5	(2)	61.5	(4)
Help in eating/with general health																	
I had all the help I needed from staff to eat my meals(acute) or with my general health(community)	Yes always	63.5	(5)	64.0	(4)	69.2	(2)	53.5	(7)	20.0	(8)	75.0	(1)	67.6	(3)	61.5	(6)
Overall views																	
Did you want to complain about the care you received in hospital-service?	No	85.5	(6)	87.8	(5)	88.5	(3)	93.1	(1)	70.0	(7)	68.8	(8)	88.2	(4)	92.3	(2)
Overall how do you rate the care you received?	Excellent/Very Good	64.8	(7)	79.1	(5)	84.6	(4)	92.1	(1)	60.0	(8)	87.5	(3)	88.2	(2)	76.9	(6)
Overall would you recommend this hospital-service to your friends and family?	Definitely yes	47.2	(7)	56.1	(6)	57.7	(5)	86.1	(1)	30.0	(8)	62.5	(4)	82.4	(2)	76.9	(3)

6.4.3 Summary

The data presented on patient experience drawn from the PEECH and Picker tools show high correlation between the two instruments. Our results also show consistency in reported patient experience in the individual microsystems with patients in ACNS1 reporting the poorest patient experience in community services and patients in EAU the poorest in the acute setting. Patients report the highest experience consistently in ACNS2 and in haematology in acute care. The results from our PEECH tool suggest that, particularly in the low performing systems, patients feel that staff are not getting to know them as individual.

6.5 Phase II: Staff survey

6.5.1 Staff profile

Three hundred and one staff responded at time 1 (40% response rate) and here (and see Appendix 21 for tables) we detail the profile of these respondents.

In terms of gender, only 10% reported being male which is proportional to the number of men in nursing generally. Medicine for the elderly was the only microsystem where there was a relatively high proportion of male staff (32%). The staff age median was 41-50 with staff working in the acute microsystems generally younger than staff working in the community. Our sample was 85% white, the community microsystems had a higher proportion of staff from ethnic minorities.

Teamwork

Nearly all staff said they were part of a team (97%), with 84% stating their team had clear objectives; the one exception was the first adult community nursing service (ACNS1) where 38% of staff stated that this was not the case. This group also said they did not work closely with other team members to achieve the team's objective (21%). The proportion of staff who met as a team to discuss effectiveness and improvements varied much more considerably than the previous two elements of teamwork (Table 40). On the whole the proportion was lower in the acute microsystems. In three acute microsystems it ranged from 63% to 71% and from 75% to 90% in three of the community microsystems. This aspect of teamwork was least likely to happen in the emergency admissions unit (EAU) (33%) and in the first adult community nursing service (59%). In terms of core members of the team; staff working in the acute microsystems reported working with a higher number of core team members than community microsystems except for the rapid response team (RRT) (see Appendix 21). This is as much a reflection of the size of the service as anything else.

Qualifications

The majority of staff who responded either had a postgraduate qualification or a university degree (59%) (see Appendix 21). Highest levels of qualification (university degree and above) were found in haematology (94%) where there were more medical staff, and in the community matron service (100%) which by its nature would be employing staff with higher levels of qualifications. Staff employed in the rapid response team had comparatively lower levels of qualifications with less than half (45%) qualified to degree level. For a number of staff employed in medicine for the elderly (21%) and the rapid response team (16%) NVQs were their highest qualification.

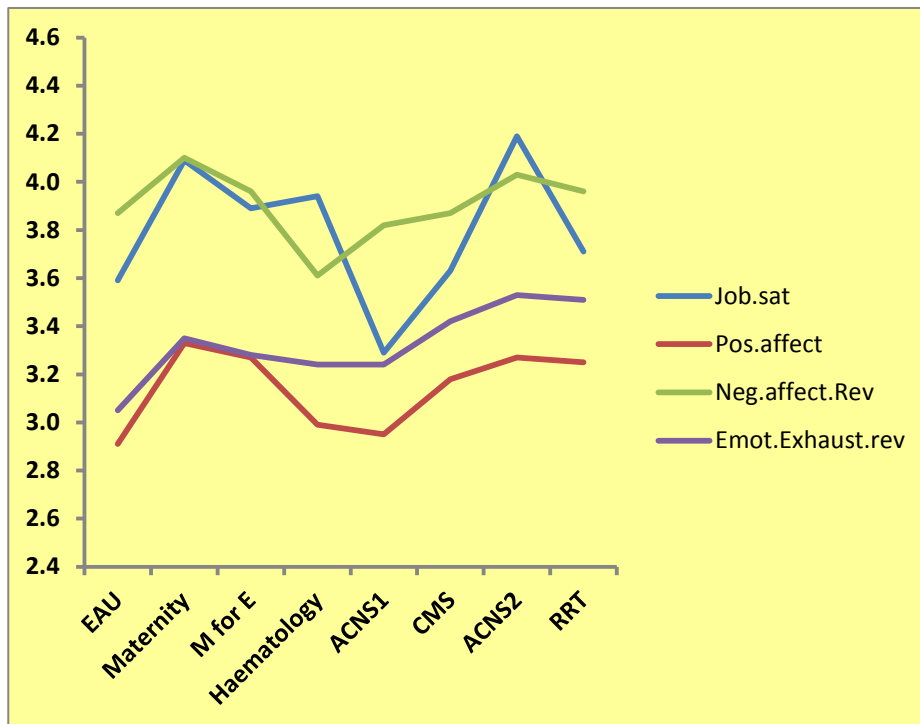
Occupational group

The majority of staff who responded to the survey were registered nurses or midwives (59%). The next largest occupational group were nursing and healthcare assistants (31%) (see Appendix 21). The highest proportion of medical staff worked in medicine for the elderly (17%) and haematology (19%). Not surprisingly the rapid response team had a high proportion of allied health professionals (35%) (paramedics). This microsystem also had the highest proportion of nursing and healthcare assistants (55%), followed by medicine for the elderly (44%).

6.5.2 Staff variables by microsystem

In this section we present findings by categorisation of staff variable (Wellbeing, Climate, Job performance, Individual difference and Job Demands and Resources) and microsystem. The staff variables grouped under these categories are shown in Figure 19 in Chapter 7 and Figure 20 in Chapter 8. See Appendix 22 for the definitions of all the measures used in the staff survey. The findings presented here relate specifically to time 1 of the survey.

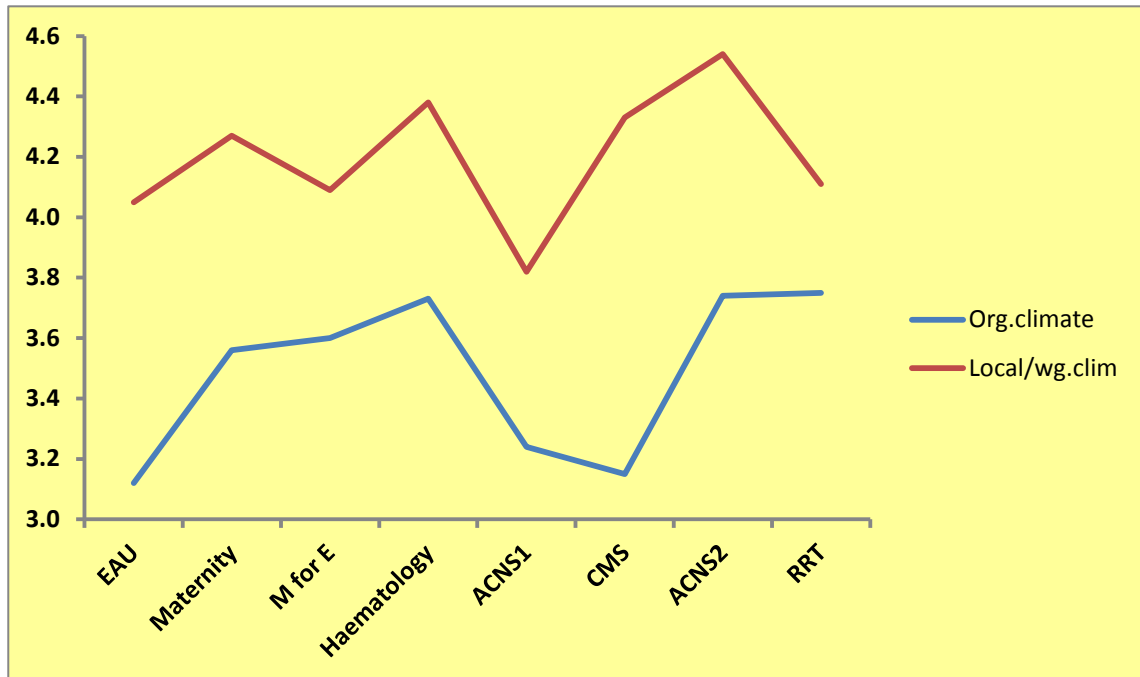
Figure 24. Wellbeing by microsystem



*Emotional exhaustion and Negative affect have been reverse scored so that 5=good and 1=bad for all scales. Neither negative affect nor emotional exhaustion varied significantly across micros-systems.

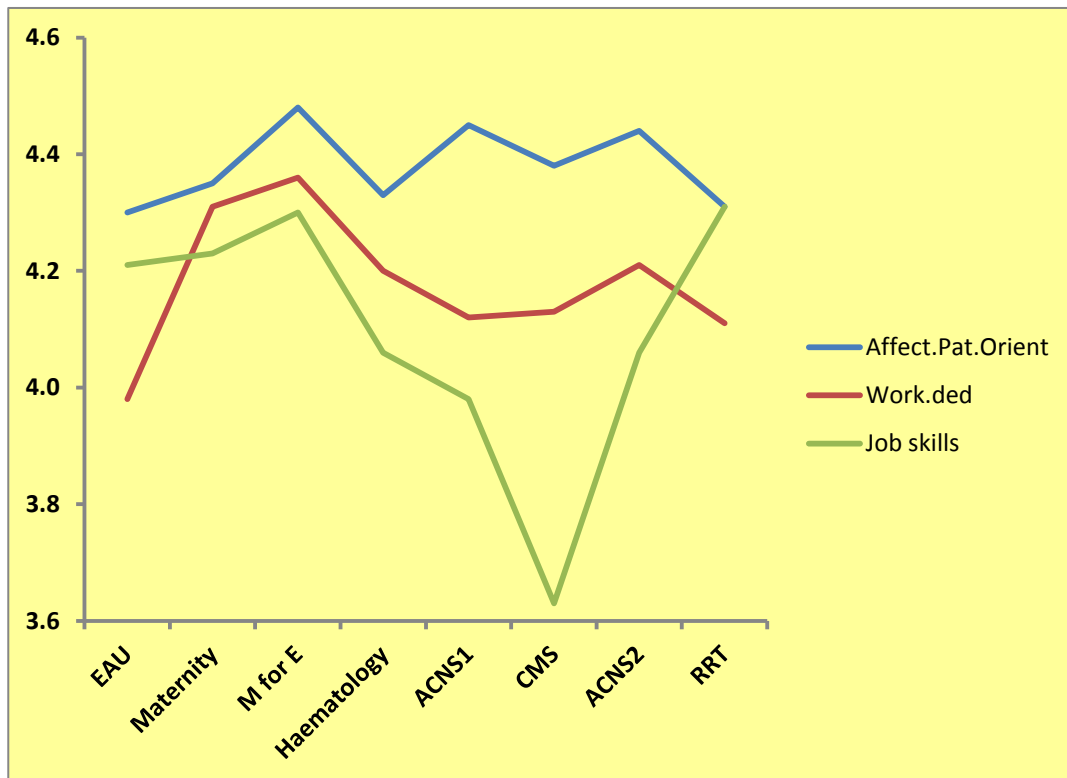
The profiles for positive affect, negative affect and emotional exhaustion follow each other reasonably closely. Staff generally rate negative affect (in a beneficial sense) and job satisfaction higher than positive affect and emotional exhaustion (Figure 24). Haematology is the microsystem that follows the overall trend less closely. The Job satisfaction profile displays far greater variability than the other wellbeing variables and for the first adult community nursing service (ACNS1), community matrons' service (CMS) and rapid response team (RRT) is below what would be expected based on the other variables. Job satisfaction is also on the low side for the emergency admissions unit (EAU) but it does seem to be in unison with the other variables. Conversely job satisfaction is higher than would be expected for haematology and the second adult community nursing service (ACNS2).

Figure 25. Organisation and local/work-group climate by microsystem



The profiles for organisational and local/work-group climate track each other closely perhaps with the exception of medicine for the elderly (M for E) and the rapid response team (RRT). What is abundantly clear is that staff working in all of these microsystems rate their local/work-group climate higher than the organisational climate (Figure 25). The largest differences between these two measures of climate were found in the emergency admissions unit (EAU) and the community matrons' service (CMS).

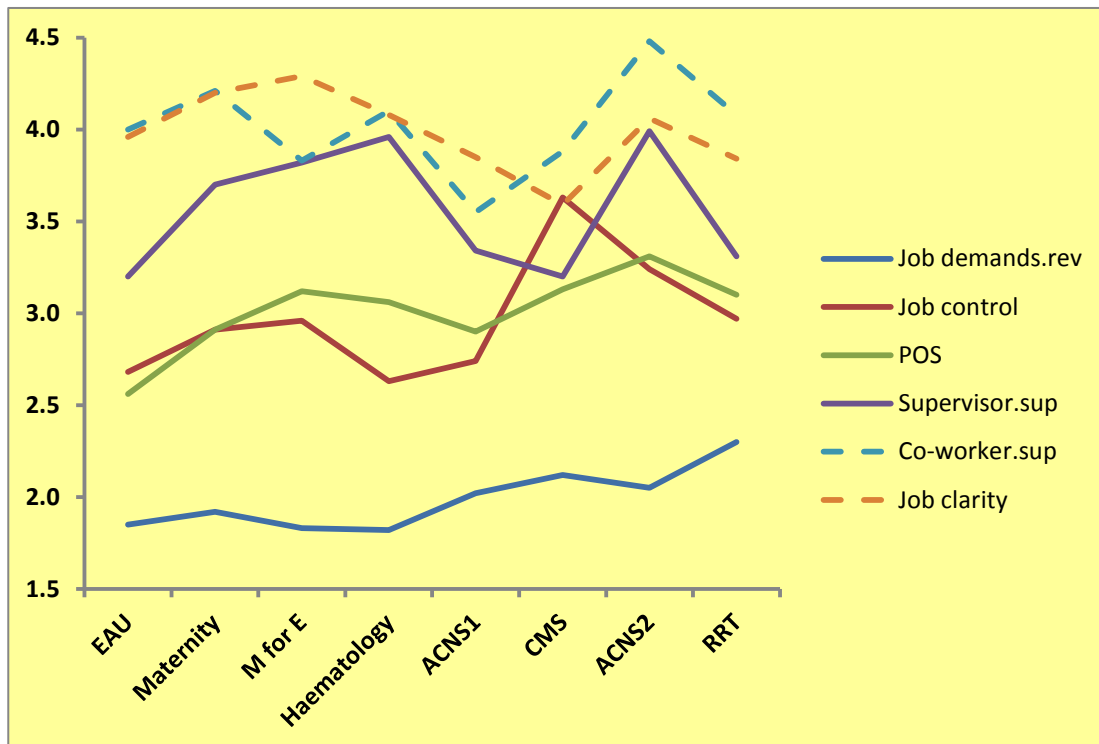
Figure 26. Individual difference variables by microsystem



*Affective patient orientation did not vary significantly across microsystems

Self ratings are highest for affective patient orientation and lowest for job skills in six of the microsystems (Figure 26). The community matron services (CMS) underrate their job skills when compared to the other microsystems, which is surprising given that this is a highly qualified group of staff. The profiles for the rapid response team (RRT) and the emergency admissions unit (EAU) are interesting because they do not follow the trend found in the other microsystems. Based on their affective patient orientation and work dedication they rate their job skills higher than would be expected or conversely based on job skills affective patient orientation and work dedication were lower than expected. Work dedication is lowest in EAU and highest in Medicine for the Elderly (M for E).

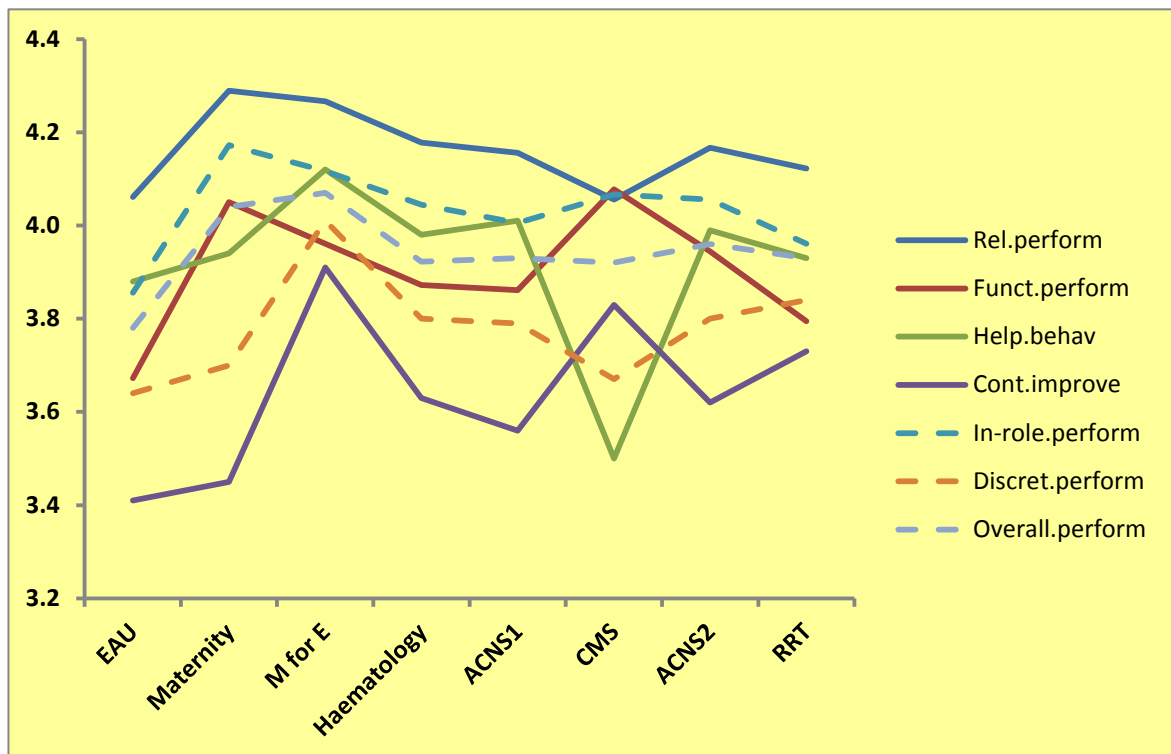
Figure 27. Job demand and resources variables by microsystem



None of these variables track each other particularly closely (Figure 27). The job demands placed on staff in all the microsystems is clearly very high particularly in the acute microsystems. The fact that community matrons have a high degree of job control is self-evident but this is matched by lower levels of job clarity compared with other microsystems. Staff working in haematology have high levels of supervisor support but low levels of job control possibly because the former acts against the latter in this particular service.

In the emergency admissions unit (EAU) and maternity co-worker support exceeds supervisor support whereas in haematology and medicine for the elderly there is little difference. In all community microsystems co-worker support exceeds supervisor support. Perceived organisation support is comparatively flat and at lower levels than either co-worker or supervisor support except for the community matrons' service and the rapid response teams where it is somewhat closer to supervisor support.

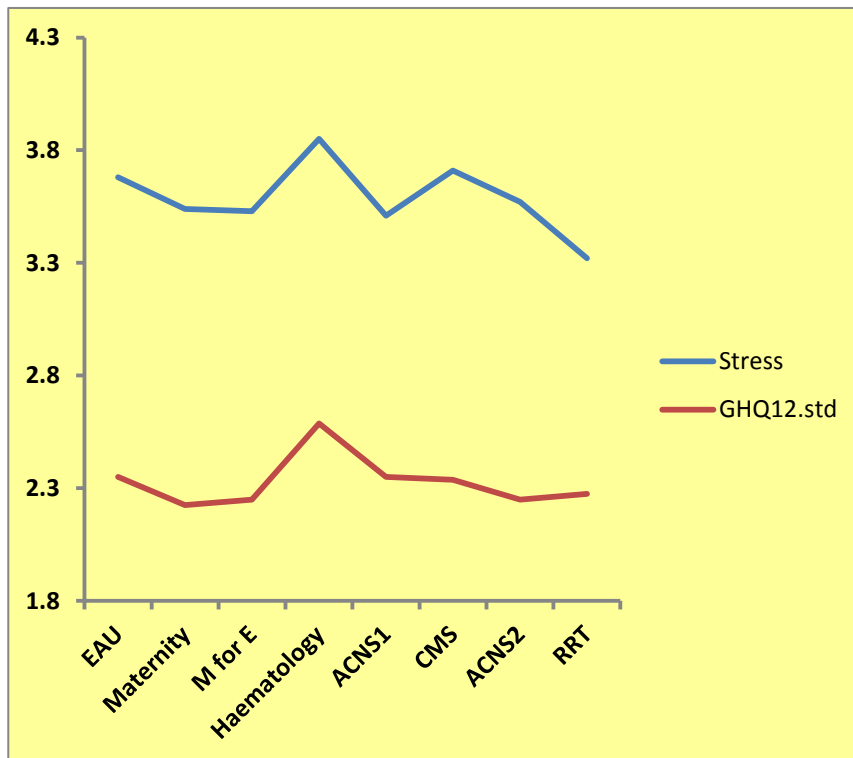
Figure 28. Self-rated job performance variables by microsystem



*Relational, functional, in-role and overall performance did not vary significant across microsystems

Generally microsystems do best in terms of self rated relational performance and less well in terms of self rated continuous improvement (Figure 28). The profile for the community matrons' service (CMS) is clearly out of line with the other microsystems. Functional performance and continuous improvement are higher, and helping behaviour and relational performance lower than expected when compared with the other microsystems. The profile for medicine for the elderly (M for E) is flatter than the other microsystems and higher overall with highest mean scores on four out of the seven performance variables (helping behaviour, continuous improvement, discretionary performance and overall performance). Staff indicated that there were low levels of continuous improvement in both the emergency admissions unit (EAU) and maternity conversely functional, relational and in-role performance are at their highest in maternity.

Figure 29. Job stress and GHQ12 by microsystem



*neither stress nor GHQ12 varied significantly across microsystems

Both stress and GHQ12 tracked each other closely but apart from haematology there was little variation between microsystems (Figure 29). The Job Stress scale reported here was constructed from three items (i) I often feel under pressure at work; (ii) I worry a lot about my work outside office hours and (iii) my job is stressful.

6.5.3 Summary

Of 301 respondents, nearly all reported being part of a team, with only ACNS1 reporting poor teamwork across a number of items. EAU also reported not meeting as a team regularly to discuss effectiveness and improvements. In terms of wellbeing variables job satisfaction displayed the greatest variability and for the first adult community nursing service (ACNS1), community matrons' service and rapid response team (RRT) was below what would be expected based on the other variables. Conversely, job satisfaction was higher than expected for haematology and the second adult community nursing service (ACNS2). Staff in all microsystems rated their local/work-group climate higher than the organisational climate. The community matron services (CMS) underrated their job skills when compared to the other microsystems and rapid response team (RRT) and the emergency admissions unit (EAU) rate their job skills higher than would be expected. All staff have high job demands, particularly in the acute microsystems. Staff working in haematology have high levels of supervisor

support but low levels of job control. In emergency admissions unit (EAU) and maternity co-worker support exceeds supervisor support whereas in haematology and medicine for the elderly (Elmwick trust) there is little difference. In all community microsystems co-worker support exceeds supervisor support. Generally microsystems do best in terms of self rated relational performance and less well in terms of self rated continuous improvement. Stress and GHQ12 tracked each other closely but apart from haematology, where stress was high and GHQ showed poor health, there were no significant differences.

6.6 Patient and staff survey results: a descriptive analysis

Following our individual analysis of the patients survey and time 1 staff survey (301 responses), which we have outlined above, we analysed the two data sets together, to determine any correlations.

The seven staff variables that correlated most strongly with patient experience (average correlation across the eight microsystems with the four patient experience variables > 0.5) were in order of magnitude local/work-group climate(average $r = 0.81$), co-worker support (0.74), job satisfaction (0.73), organisational climate (0.71), perceived organisational support (0.64), emotional exhaustion (0.59) and supervisor support (0.56). See Table 16 and 17 for correlation tables.

Table 16. Seven staff variables correlated with patient experience

	Organisational and local work-group climate		Well Being				Individual Differences		
	Organisational Climate	Local/Workgroup Climate	Job Satisfaction	Positive Affect	Negative Affect (reversed scored)	Emotional Exhaustion (reversed scored)	Affective Patient Organisation	Work Dedication	Skills and competence
Picker Index(PPE-15) (reverse scored)	.842**	.632	.613	.412	.038	.680	-.224	.237	.143
Picker - overall rating of care	.589	.918**	.784*	.554	.057	.571	-.025	.424	-.142
Picker - recommend to friends/family	.875**	.725*	.773*	.385	-.018	.466	-.240	.292	.327
Overall PEECH	.514	.950**	.735*	.533	.108	.645	-.171	.250	-.228

	Job demand and resources						Job Performance				
	Job Demands (reverse scored)	Job Control	Positive Organisational Support	Supervisor Support	Coworker Support	Job Clarity	Relational Performance	Functional Performance	In role Performance	Discretionary Performance	Overall Performance
Picker Index(PPE-15) (reverse scored)	.364	.053	.613	.545	.705	.122	.211	.138	.244	.144	.230
Picker - overall rating of care	.051	.499	.716*	.588	.697	.153	.127	.471	.431	.169	.327
Picker - recommend to friends/family	.058	-.019	.542	.678	.791*	.365	.222	-.002	.152	.296	.191
Overall PEECH	.217	.568	.665	.446	.769*	-.024	-.027	.439	.332	-.047	.181

** < 0.01 (2-tailed); * < .05 (2-tailed)

Table 17. Patient experience correlations

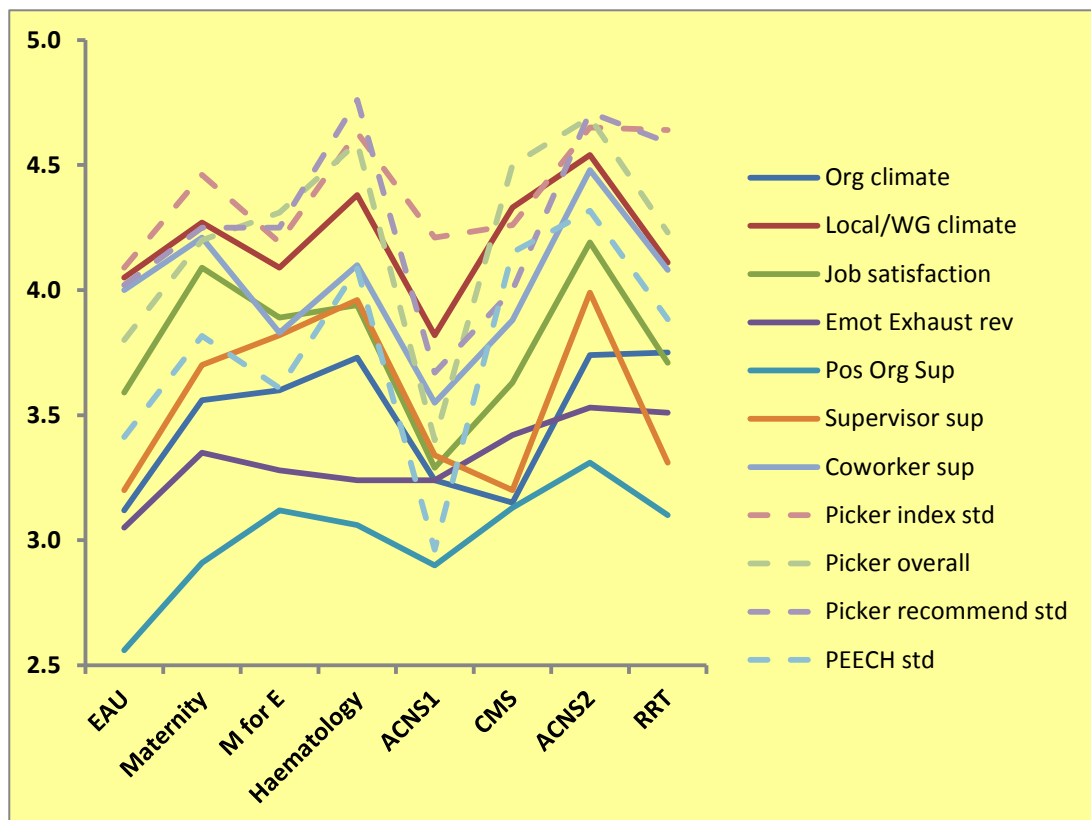
	Picker Index (reverse scored)	Picker Overall	Picker Recommend	Overall PEECH
Picker Index (reverse scored)	1	.620	.854**	.680
Picker Overall	.719**	1	.790*	.963**
Picker Recommend	.596**	.717**	1	.762*
Overall PEECH	.692**	.773**	.608**	1

** < 0.01 (2-tailed); * < .05 (2-tailed)

Note: correlations at the patient level are shown below the diagonal and at the microsystem level above the diagonal.

The seven staff variables are shown alongside the patient experience measures in Figure 30.

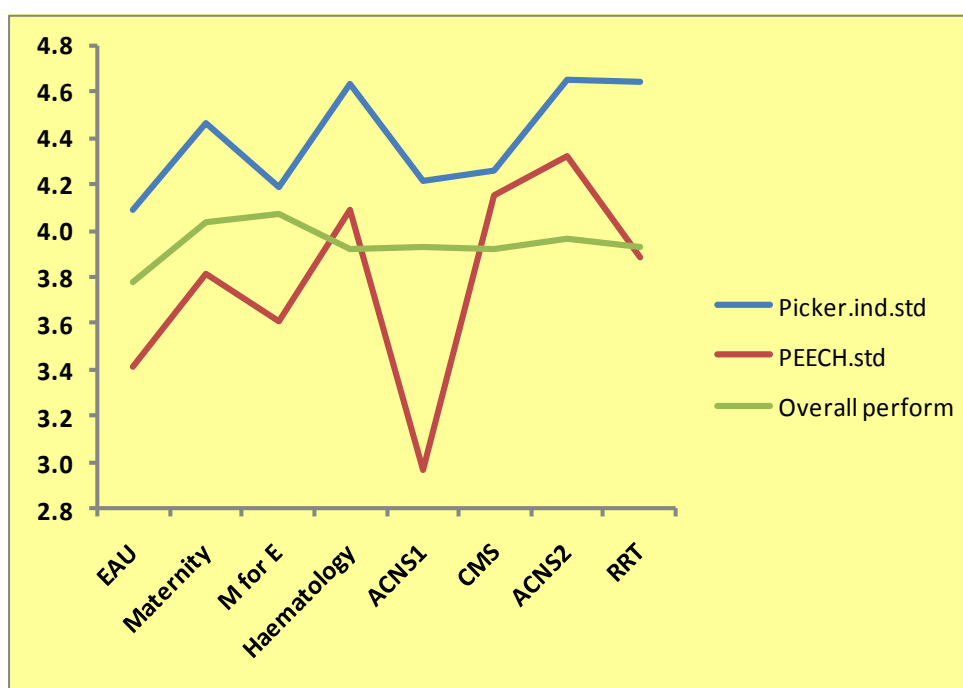
Figure 30. Staffing variables that most closely track patient experience



*Emotional exhaustion did not vary significantly across microsystems. All variables that include 'std' in the label have been standardised to a 1-5 scale (Picker index 0-15, Picker recommendation 1-4, PEECH 0-3) on the vertical axis

The final figure in this section (Figure 31) compares overall performance as perceived by staff with PEECH and the Picker index (PPE-15). There is little variation amongst staff regarding performance; yet staff appear to underrate themselves on functional items (Picker) and overrate themselves on relational items (PEECH). In role performance is based on Shaller (96) which includes both functional and relational aspects of care. See Table 16 and 17 above for correlation table.

Figure 31. Performance as rated by patients and staff



Based on the Picker Index the four microsystems that perform least well are the emergency admissions unit (EAU), medicine for the elderly (M for E), the first adult community nursing service (ACNS1) and the community matron service (CMS). For PEECH the least well performing are the emergency admissions unit (EAU), medicine for the elderly (M for E) and the first adult community nursing service (ACNS1).

Overall self-reported performance is relatively flat by comparison; the emergency admissions unit (EAU) performs least well but this is very marginal and the two highest performers are maternity and medicine for the elderly (M for E). Therefore the greatest disparity between self-reported performance and performance rated by patients is observed for the first adult community nursing service followed by medicine for the elderly, the emergency admissions unit and maternity.

6.6.1 Summary

A number of the staff measures track the patient performance measures closely in particular local/work-group climate, co-worker support, job satisfaction, and organisational climate. Where these are high so is performance. Where staff do not meet in teams regularly and discuss effectiveness and how it could be improved performance is lower. The two microsystems where this most applied were the early admissions unit and the first adult community nursing service. The profiles for individual components of PEECH were all quite similar. All microsystems performed less well on level of connection which is a measure of how meaningful relationships were between staff and patients. Staff in some microsystems had tendency to overrate and others to underrate their performance and this was more evident in the acute than the community microsystems although the largest disparity was found in the first adult community nursing service which performed consistently below the other microsystems on all components of PEECH. The Picker Index was less discriminatory than either Picker overall, Picker recommend and PEECH.

7 Results: Phase II staff survey: Employee wellbeing and patient care behaviour and performance

7.1 Introduction

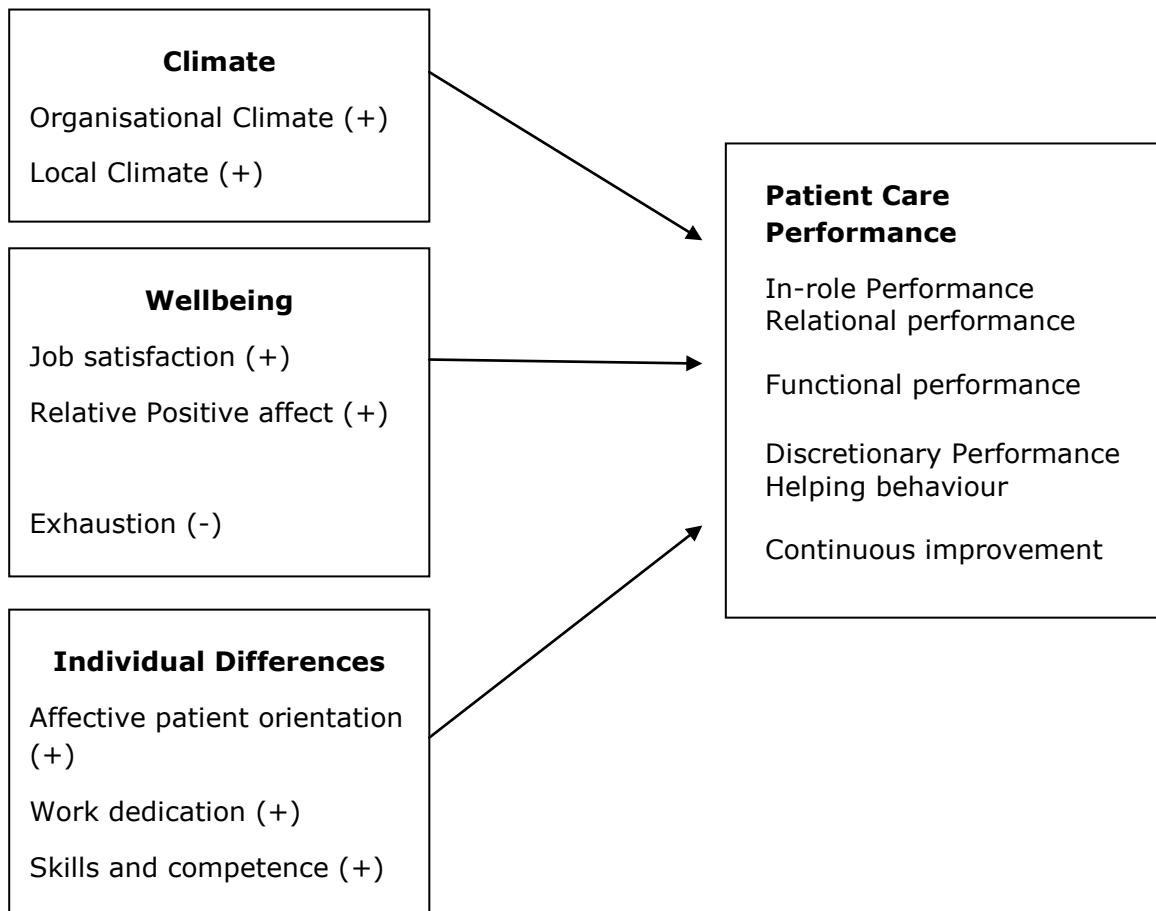
As noted, a central aim of the present project is, first, to explore the importance of employee wellbeing as an antecedent of patient care behaviour/performance relative to other core potential antecedents of PCBP and, second, to identify key potential antecedents of employee wellbeing itself. In this and the following Chapter we use the quantitative data collected as part of our repeat employee surveys to examine these two core issues. Specifically, in this Chapter we use the two-wave panel data from our two surveys to examine the relationship between employee wellbeing and patient-care behaviour/performance. In the following chapter we then use the panel data to explore key antecedents of wellbeing at work.

The rest of this chapter is organised as follows. In the next section, based on the discussion of the overall framework for the quantitative part of the study presented in Chapter 2, we first provide a schematic summary of the general explanatory model used to analyse the relationship between employee wellbeing and patient care behaviour/performance. We also outline the specific hypotheses about the direct antecedents of PCBP that we tested in the present analysis. In this context, it is important to note that the specific measures and procedures used in the analysis were presented in the methods chapter and will not, therefore, be discussed again here. Hence, after outlining the key hypotheses we proceed directly to present the results of the analysis which are then discussed in the last section of the chapter.

7.2 Basic research model: Hypothesised antecedents of patient care behaviour/performance

As noted in Chapter 2, there are three main sets of factors, including employee wellbeing, that can be expected to have a direct effect on employee patient care behaviour/performance and that we focused on in the present study. The relevant factors are shown in the basic model of the antecedents of PCBP summarised in Figure 32 below.

Figure 32. Antecedents of patient care performance



Note that to simplify the analysis, we combined positive and negative affect into a single measure designed to assess the overall difference in individuals' level of positive versus negative affect at work. We labelled this new measure relative positive affect although, for ease of presentation, we use the term relative positive affect and positive affect interchangeably in the following discussion.

Based on the model the following set of specific hypotheses were tested in the analysis using the panel data.

Employee wellbeing hypotheses

Hypothesis 1: Job satisfaction will have a positive effect on in-role and discretionary patient care performance.

Hypothesis 2: Relative positive affect will have a positive effect on in-role and discretionary patient care performance.

Hypothesis 3: Emotional exhaustion will have a negative effect on in-role and discretionary patient care performance.

Climate hypotheses

Hypothesis 4: Organisational climate for patient care will have a positive effect on in-role and discretionary patient care performance.

Hypothesis 5: Local climate for patient care will have a positive effect on in-role and discretionary patient care performance.

Individual difference hypotheses

Hypothesis 6: Affective patient orientation will have a positive effect on in-role and discretionary patient care performance.

Hypothesis 7: Work dedication will have a positive effect on in-role and discretionary patient care performance.

Hypothesis 8: Employee skills will have a positive effect on in-role and discretionary patient care performance.

7.3 Results

7.3.1 Correlation analysis

Table 18 shows the correlation between all the main variables in the analysis. Several points are worth noting about the correlation results. The first point concerns the interrelation between the performance measures. Because of the composite nature of the in-role, discretionary and overall performance measures, these measures are necessarily highly correlated with each other and with the other performance variables. Quite apart from these statistical artefacts, however, the performance measures, as might be expected, are all positively and significantly inter-correlated.

Table 18. Correlations between main variables in the analysis

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1															
2	.06														
3	-.06	-.62***													
4	.01	.68***	-.65***												
5	.15+	.47***	-.38***	.42***											
6	.23**	.24***	-.07	.16	.35***										
7	.02	.25*	-.11	.25+	.23*	.37***									
8	.08	.47***	-.21**	.42***	.27**	.28***	.65***								
9	.18+	.32***	-.20***	.43***	.21)	.28**	.41***	.52***							
10	.14	.23***	-.02	.24**	.19+	.26***	.44***	.39**	.36***						
11	.32***	.16+	-.02	.16	.17	.32**	.36***	.33***	.36***	.73***					
12	.02	.16+	.10	.17	.14	.15+	.38***	.44***	.28***	.48***	.34***				
13	.42***	-.12*	.17+	-.04	.05	.18	.16+	.21**	.15	.25***	.30***	.46***			
14	.27**	.20**	-.02	.21*	.19	.32***	.42***	.38***	.39***	.90***	.96***	.42***	.30***		
15	.28**	.00	.17+	.06	.10	.19*	.30*	.36***	.24*	.41***	.37***	.82***	.89***	.42***	
16	.33**	.16**	-.02	.20+	.22+	.31***	.40***	.39***	.38***	.84***	.87***	.63***	.59***	.92***	.68***

Variables:

1 = Supervisory responsibility (time 1)

2 = Job satisfaction (time 1)

3 = Emotional exhaustion (time 1)

4 = Positive Affect (relative) (time 1)

5 = Organisational climate for patient care (time 1)

6 = Local climate for patient care (time 1)

7 = Affective patient orientation (time 1)

8 = Work dedication (time 1)

9 = Job Skills and competence (time 1)

10 = Relational patient care performance (time 2)

11 = Functional patient care performance (time 2)

12 = Helping behaviour towards patients (time 2)

13 = Continuous improvement behaviour towards patients (time 2)

14 = Overall in-role patient care performance (time 2)

15 = Overall discretionary patient care performance (time 2)

16 = Overall patient care performance (time 2)

Correlations: + $p < 0.10$, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The second point concerns the relationship between the time 1 wellbeing variables and the time 2 performance measures. This relationship is somewhat uneven. The clearest relationship is that between job satisfaction and performance. Job satisfaction is significantly related (below the 10% level) to six of the seven performance variables, although contrary to expectations, the correlation with continuous improvement behaviour is negative rather than positive ($r = -0.12$, $p < 0.05$). In contrast, (relative) positive affect is significantly positively related (below the 10% level) to only three of the seven performance measures, while emotional exhaustion is only weakly related to two of the performance variables (continuous improvement behaviour: $r = 0.17$, $p < 0.10$; and overall discretionary performance: $r = 0.17$, $p < 0.10$). In both cases, however, the relationship is positive rather than negative, suggesting that higher levels of emotional exhaustion are associated with higher, rather than lower, levels of continuous improvement behaviour and overall discretionary performance.

The third point concerns the relationship between the two climate measures at time 1 and the performance variables at time 2. As can be seen from Table 18, patient care performance is much more strongly and clearly related to the local than to the organisational-level climate variable. Except for a weak positive association with relational patient care performance, ($r = 0.17$, $p < 0.10$), the organisational climate variable is not significantly associated with any of the performance measures. In contrast, local climate for patient care is significantly positively related to six of the seven performance measures.

The last point concerns the correlation between the various individual difference variables at time 1 and patient care performance at time 2. As can be seen, consistent with our hypotheses in this area, all three individual variables were strongly and positively related to virtually all measures of performance.

Overall, therefore, the correlation results are broadly consistent with our hypotheses. However, the results suggest that the link between wellbeing and various aspects of patient care performance may not always be all that strong or consistent. Also, in terms of the climate for patient care, the correlation results suggest that it is the local rather than the organisational-level climate in this area that is most important for patient care performance.

In the next section we use multiple regression analysis to provide a more detailed and systematic test of our hypotheses. In particular, we use multivariate analysis to identify the relative effect of each of the antecedents at time 1 on performance at time 2, while simultaneously controlling for the effect of all other time1 antecedents on the lagged performance variable.

7.3.2 Test of hypotheses

The results of the regressions designed to test the study hypotheses are shown in Table 19. Before considering the results for the individual hypotheses, two points are worth noting about the model as a whole. First, as can be seen from the R² values at the bottom of the table, the model as a whole performs quite well, accounting for between 27% and 33% of the variance in the different measures of patient care performance. And second, although the specific antecedents of performance vary somewhat depending on the aspect of performance involved, the model as a whole performs equally well in relation to both in-role and discretionary performance (in-role performance R² = 0.304, $p < 0.001$; discretionary performance R² = 0.293, $p < 0.001$).

Table 19. Test of hypotheses. Factors affecting patient care performance (time 1 → Time 2)

Predictors at Time 1	Relational Performance Time 2	Functional Performance Time 2	Helping Behaviour Time 2	Continuous Improvement Behaviour Time 2	Overall In-role Performance Time 2	Overall Discretionary Performance Time 2	Overall Performance Time 2
<i>Controls</i>							
Supervisor responsibility	.087	.255***	.001	.401***	.204***	.257**	.280***
<i>Wellbeing</i>							
Job satisfaction	.096	.045	.105	-.229+	.071	-.089	-.048
Emotional Exhaustion	.217**	.149**	.391***	.202**	.189***	.342***	.177*
Positive affect (relative)	.139+	.069	.156+	.113	.103	.156	.137
<i>Situational</i>							
Organisational climate	.037	.007	.066	.044	.020	.055	.079
Local climate	.031	.108	-.046	.037	.083	-.022	.063
<i>Individual</i>							
Affective orientation	.297***	.208*	.170	.037	.261**	.119	.217*
Work dedication	.049	.041	.279**	.256***	.047	.304***	.130
Skills/competences	.131+	.162	.041	-.024	.160*	.005	.130+

Standardised estimates: + p < 0.10, * p < 0.05, ** p < 0.01, *** p < 0.001

In terms of the individual hypotheses, the first three hypotheses proposing a link (positive for job satisfaction and positive affect, and negative for emotional exhaustion) between wellbeing and patient care performance, found little or no support in the data. Specifically, once the influence of all other factors is taken into account, the effect of job satisfaction at time 1 on performance at time 2 is minimal. As can be seen, job satisfaction is only weakly related to one of the performance measures, continuous improvement ($\beta = -0.229$, $p < 0.10$). Moreover, the relationship is negative rather than positive, suggesting a weak tendency for satisfied individuals to engage in less rather than more continuous improvement behaviour towards patients. Relative positive affect is positively, but only weakly related to two of the performance measures, relational performance ($\beta = 0.139$, $p < 0.10$), and helping behaviour towards patients ($\beta = 0.156$, $p < 0.10$). In contrast, emotional exhaustion is significantly and strongly related to all the performance measures. Contrary to expectations, however, the relationship in all cases is positive rather than negative, suggesting that high levels of emotional exhaustion at one point in time are associated with higher, rather than lower subsequent levels of patient care performance.

The two climate hypotheses proposed a positive effect of both organisational and local climate for patient care on patient care performance. As shown in Table 19, the results of the regression analysis do not support the climate hypotheses. Once the influence of other factors is taken into account, neither the organisational nor the local climate variable has a significant effect on any of the performance measures.

Finally, the three individual difference hypotheses propose a positive effect of all three individual variables on patient care performance. The results of the analysis provide quite strong support for these hypothesised relationships. The results also show that the three individual variables are differentially related to the different aspects of patient care performance. Specifically, affective patient orientation is significantly and positively related primarily to the two aspects of in-role performance (β : relational performance = 0.297, $p < 0.001$; functional performance = 0.208, $p < 0.05$), while work dedication is significantly and positively related primarily to the two aspects of discretionary performance (β : helping behaviour = 0.279, $p < 0.01$; continuous improvement behaviour = 0.256, $p < 0.001$). The skills variable, on the other hand, is mainly related to in-role performance ($\beta = 0.160$, $p < 0.05$), although the relationship here is generally weaker than for the affective patient orientation variable.

Overall, therefore, the results of the multivariate analysis suggest that the individual difference variables are the strongest predictors of patient care performance, followed by the wellbeing variables, with the situational climate variables having virtually no effect of their own. However, the direction of the relationship between some of the wellbeing variables and patient care performance and, in particular, the effect of emotional exhaustion, is not as expected in that high levels of exhaustion appear to be

associated with higher, rather than lower levels of both in-role and discretionary performance.

7.3.3 Additional analyses

In order to check the robustness of the results of the main analysis presented above we conducted a number of additional analyses. These additional analyses are particularly important given the relatively small and positively biased nature of our sample. Four additional sets of analyses were performed designed to test the sensitivity of the results to the use of different model specifications, ways of measuring patient care performance and data samples, and in order to explore key interaction effects in our data. The detailed results of these various analyses are presented and discussed in Appendix 22. Overall, the results of these additional analyses suggest that the results of the main analysis are quite robust in that they do not appear to be overly sensitive to alternative measure, model and data specifications. At the same time, the results of the additional interaction analyses suggest that the relationship between wellbeing and various aspects of both in-role and discretionary patient care performance is quite complex. In particular, as we highlight in the overall discussion below, the results of the interaction analyses suggest that the wellbeing-performance relationship is affected by a range of both contextual and individual factors linked to the climate for patient care at different levels of the organisation and to employee skills and orientations at work.

7.4 Discussion

In this chapter we used panel data covering a sample of 122 direct contact employees to address the central question of the study and examine the relationship between employee wellbeing and patient care performance. To this end we first developed and presented an overall model of the antecedents of both in-role and discretionary patient care performance grounded in the wider OB, OP and service management literature. Central to this model is the idea that patient care performance is a function of three main sets of personal and contextual factors: employee wellbeing, the climate for patient care at different levels of the organisations and employee skills and orientations at work. To examine the relative importance of these various antecedents, we then tested the model using two-wave panel data.

Despite the relatively small size of the panel sample, the results of the main analysis appear to be quite robust. The findings direct attention to a number of important points concerning the effect of employee wellbeing on performance, as well as the more general antecedents of high quality patient care behaviour and performance at work. The first key point concerns the relative importance of wellbeing as an antecedent of performance compared to the other climate and individual difference factors included in the model. The results of the main analysis indicate that the individual difference variables, namely, affective patient orientation, work

dedication and job skills and competence, have by far the strongest direct effect on both in-role and discretionary patient care performance. The two climate variables have no significant main effect on performance, while the direct effect of wellbeing on performance is both limited and uneven. In particular, the results from the main analysis show that, overall, the impact of both job satisfaction and relative positive affect on the various aspects of patient care performance tends to be weak and inconsistent. The impact of emotional exhaustion is far stronger and more consistent. Contrary to expectations, however, this impact is positive rather than negative, indicating that higher levels of emotional exhaustion are associated with higher rather than with lower levels of both in-role and discretionary performance.

There are a number of possible explanations for this unexpected positive relationship between exhaustion and performance. One possibility is that this result is a statistical artefact, a function of complex suppression effects in the data. A second possibility is that the direction of the relationship is from performance to exhaustion, rather than from exhaustion to performance as hypothesised in our model. In other words, high levels of job performance may contribute to exhaustion, thereby resulting in a positive relationship between exhaustion and performance. We explore this possibility more fully in the following chapter when we explicitly examine the antecedents of wellbeing and use past performance as a potential predictor of subsequent emotional exhaustion at work. However, as we discuss more fully in the next chapter, performance at time 1 does not emerge as a significant predictor of exhaustion at time 2. Moreover, it should also be noted that in the present analysis we used exhaustion at time 1 as a predictor of performance at time 2. It is unlikely therefore, that the positive relationship found between exhaustion and performance in the main analysis can be explained in terms of the operation of reverse causality between these two variables.

A more plausible explanation is linked to the complex nature of nursing and health care jobs and the difficulty individuals may have in such complex work contexts to evaluate their own personal day-to-day contribution to the patient experience and ultimately, therefore, to assess the quality of their own patient care performance. In these circumstances, it is possible that individuals end up equating high emotional and physical exhaustion to high effort and performance at work, in the sense that, in their own mind, exhaustion becomes a tangible and concrete sign of the amount of effort they are putting into their job and indirectly, therefore, also a sign that they are performing to a maximum at work. In other words, in the absence of clear and explicit criteria for assessing individual contribution on the job and, in particular, personal contribution to patient welfare, physical and emotional exhaustion may, in employees' mind, become a proxy for job effort and performance. And this, in turn, would go some way in accounting for the positive relationship found between exhaustion and performance in the main analysis.

There is no doubt, however, that this particular relationship is potentially quite complex and that it requires further systematic research using larger and more diverse samples of employees in a variety of different organisations, both within and outside the health sector.

The other main points to emerge from the present analysis are linked to the interaction effects we explored as part of the additional analysis of the panel data. Most fundamentally, the additional analysis showed that, to an important extent, patient care performance is a function of the interaction between the person and the situation. Specifically, it is a function of the interplay between the organisational context and individual factors linked not only to employee wellbeing, but also to individual skills and orientations at work. It is within this broader person-situation perspective, therefore, that the effect of wellbeing on patient care performance can best be understood. In particular, our findings show that the impact of wellbeing on both in-role and discretionary patient care performance is contingent on a number of other situational and individual level factors. The detailed findings are presented in Appendix 22. Three key points, however, stand out in this respect.

First, our findings suggest that in order to gain a better understanding of the impact of wellbeing on performance it is important to consider different dimensions of wellbeing simultaneously and conjointly since different aspects of wellbeing interact with each other to produce performance outcomes of interest. In particular, the effect of job satisfaction and relative positive affect on various aspects of patient care performance is mutually reinforcing so that employees who exhibit high levels of both satisfaction and positive affect tend to perform better than other employees, including those who are high on only one or the other of these two dimensions of wellbeing. In contrast, emotional exhaustion dampens the effect of job satisfaction and relative positive affect on performance, so that the positive effects of satisfaction and positive affect on performance tend to be nullified by high levels of exhaustion.

Second, our findings show that the effect of wellbeing on performance depends, at least in part, on the climate for patient care at the level both of individual work units and of the organisation as a whole. In particular, our results indicate that a strong climate for patient care at local and organisational level can help to reinforce some of the positive effects of wellbeing on performance. It can also act as a substitute for wellbeing in the sense of making up for the absence of high levels of wellbeing in terms of performance.

Finally, our findings show that the impact of wellbeing on performance is also significantly moderated by key characteristics of individuals. In particular, high commitment and dedication to the job, as well as high levels of job competence and a strong affective patient orientation, help to enhance the positive effect of job satisfaction and positive affect on performance. In other words, our results show that key aspects of wellbeing

and core employee skills and orientations at work are mutually reinforcing and have a strong and significant complementary effect on patient care performance.

Taken together the above findings have important implications for the management of front-line staff in health organisations. Most fundamentally, our analysis suggests a win-win model of the relationship between employee wellbeing and patient care performance. In particular, it suggests that high levels of patient care performance need not necessarily be achieved at the expense of employee wellbeing. On the contrary, our findings point to a mutual gains model, whereby employee wellbeing positively contributes to both in-role and discretionary performance and, ultimately, therefore, to the wellbeing of patients. In other words, our results suggest that patient wellbeing is positively linked to staff wellbeing and that seeking systematically to enhance employee wellbeing is, therefore, not only important in its own right, but is also important for the patient experience.

In addition, our findings indicate that developing a stronger climate for patient care at both local and organisational level, as well as ensuring high levels of skills and competences amongst front-line staff and helping to develop positive work orientations amongst the workforce, can make a significant positive contribution to patient care performance. Importantly, this contribution is both direct and indirect, with a positive climate for patient care, along with high levels of job skills and commitment to work helping, as we have seen, to reinforce the positive effect of wellbeing on performance. In turn, these findings have clear implications for the management of front-line staff in terms, for example, of the nature and quality of organisational and local leadership and supervision, the active management of organisational culture, and the systematic selection, induction, training and development of employees.

7.5 Conclusions

In this chapter we explored the link between employee wellbeing and various dimensions of patient care performance. Our results suggest that this relationship is potentially quite complex. In particular, our findings indicate that although wellbeing does not appear to have a very strong or clear direct effect on performance, there are important situational and individual level factors that help to moderate the wellbeing-performance relationship. In order to gain a fuller understanding of this relationship, therefore, it is important to take these moderator effects into consideration and view the wellbeing-performance relationship from a more general person-situation contingency perspective. Seen in terms of this broader framework, employee wellbeing then emerges as a significant antecedent of patient care performance, an antecedent whose effect on performance is contingent on a range of key situational and individual factors that help either to enhance or dampen its impact on performance.

8 Results: Phase II staff survey: Antecedents of employee wellbeing

8.1 Introduction

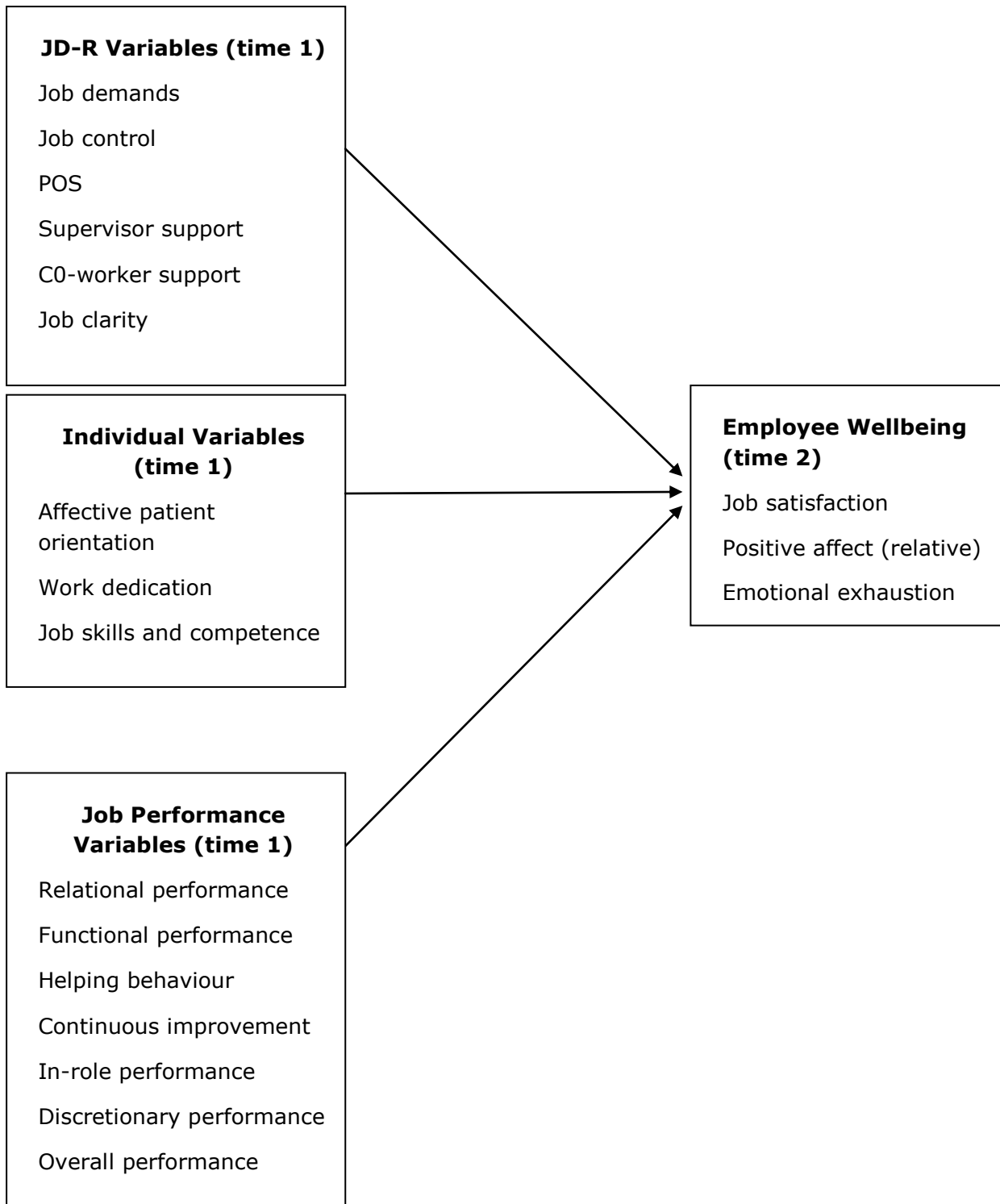
In the previous chapter we examined the link between employee wellbeing and various aspects of patient care behaviour and performance (PCBP) as part of a more general analysis of the antecedents of PCBP. The results indicate that, although the relationship between wellbeing and performance is potentially quite complex and contingent on a number of other factors, wellbeing can indeed make a significant contribution to both in-role and discretionary performance. In this chapter, therefore, we go on to address the second core aim of the present study and use the two-wave panel data to seek to gain a better understanding of key antecedents of employee wellbeing at work.

The chapter is organised as follows. Based on the discussion of the overall framework for the quantitative part of the study presented in Chapter 2, we start by providing a schematic summary of the basic model used to analyse the antecedents of employee wellbeing and by outlining the specific hypotheses that will be tested with the two-wave panel data. Once again, please note that the specific measures and procedures used in this analysis have already been presented and discussed in the methods chapter. After outlining the key hypotheses, therefore, we present the results of the actual analysis, followed by a summary discussion at the end of the chapter.

8.2 Hypothesised antecedents of employee wellbeing at work

As noted in Chapter 2, based on the wider OB and OP literature, there are three main sets of factors that we hypothesised to have an effect on employee wellbeing. These are shown in the model in Figure 33 below.

Figure 33. Antecedents of employee wellbeing



Based on the model, the following set of specific hypotheses were tested in the analysis using the panel data.

Job demands and resources hypotheses

Hypothesis 1: Job demands will be negatively related to job satisfaction and to positive affect, and positively related to emotional exhaustion.

Hypothesis 2: Job control will be positively related to job satisfaction and to positive affect, and negatively related to emotional exhaustion.

Hypothesis 3: Perceived organisational support will be positively related to job satisfaction and to positive affect, and negatively related to emotional exhaustion.

Hypothesis 4: Supervisor support will be positively related to job satisfaction and to relative positive affect, and negatively related to emotional exhaustion.

Hypothesis 5: Co-worker support will be positively related to job satisfaction and to relative positive affect, and negatively related to emotional exhaustion.

Hypothesis 6: Job clarity will be positively related to job satisfaction and to relative positive affect, and negatively related to emotional exhaustion.

Individual difference hypotheses

Hypothesis 7: Affective patient orientation will be positively related to job satisfaction and to relative positive affect, and negatively related to emotional exhaustion.

Hypothesis 8: Work dedication will be positively related to job satisfaction and to relative positive affect, and negatively related to emotional exhaustion.

Hypothesis 9: Employee skills will be positively related to job satisfaction and to relative positive affect, and negatively related to emotional exhaustion.

As noted in Chapter 2, there is considerable debate in the literature about the direction of the relationship between employee wellbeing and job performance (26). For example, emotional exhaustion, like job satisfaction, may be both an antecedent and a consequence of job performance. To explore the possibility of reverse causality between wellbeing and job performance, we included the various aspects of in-role and discretionary performance examined in the previous chapter as potential antecedents of wellbeing in the present analysis. However, because of the exploratory nature of this analysis, we do not specify any formal hypotheses about the performance-wellbeing relationship here.

8.3 Results

8.3.1 Correlation analysis

Table 20 shows the correlation between all the main variables in the analysis. Three points are worth highlighting. The first point concerns the relationship between the job demands-resources (JD-R) variables at time 1 and the wellbeing measures at time 2. As can be seen from the table, consistent with expectations, emotional exhaustion is positively related to job demands, but negatively related to all the job resources variables which, as expected, are all positively related to both job satisfaction and relative positive affect.

Table 20. Correlations between main variables in the analysis

	1	2	3	4	5	6	7	8	9	10
2	.18									
3	.23***	-.10								
4	.19**	-.32**	.39***							
5	.32***	-.09	.13+	.56***						
6	.16*	.04	.15**	.21***	.32***					
7	.17**	-.02	.23*	.25**	.39***	.17				
8	.02	.18+	.07	.18+	.25***	.31***	.24+			
9	.08	.18*	.27***	.24*	.31***	.31**	.37***	.65***		
10	.18+	.10	.27***	.11	.17*	.30**	.38**	.41**	.52***	
11	.13+	.21+	.29***	.02	.15	.19*	.26***	.41**	.39***	.50***
12	.30***	.16	.38***	.08	.13	.18***	.27***	.30***	.30**	.48***
13	.04	.31*	.12	.07	.14	.05	.22*	.56***	.44***	.39***
14	.44***	.32**	.25*	.11	.16	-.04	.11	.26*	.30***	.23+
15	.25***	.19	.38***	.07	.16	.20***	.29***	.37***	.38***	.53***
16	.30***	.36**	.23*	.11	.17	.001	.18	.46***	.42***	.35***
17	.27***	.25+	.32**	.06	.16	.11*	.25**	.44***	.41***	.45***
18	.14+	-.19	.21*	.36***	.42***	.22***	.40***	.27+	.46***	.26*
19	-.03	.51***	-.29*	-.47***	-.38***	-.22***	-.23**	-.18	-.21**	-.23*
20	.04	-.18	.28***	.41***	.33***	.31***	.34***	.34*	.45***	.36**

	11	12	13	14	15	16	17	18	19
12	.68***								
13	.50***	.31**							
14	.27*	.32+	.45***						
15	.88***	.95***	.42***	.32*					
16	.44***	.38**	.82***	.88***	.43***				
17	.80***	.82***	.66***	.61***	.87***	.73***			
18	.22**	.12*	.09	.05	.19**	.08	.14		
19	-.12+	-.06	.09	.08	-.10+	.09	-	-	
20	.32**	.16	.15	.07	.26*	.13	.21	.70***	-
							.04	.66***	.73***

Variables:

1 = Supervisory responsibility (time 1)

2 = Job demands (time 1)

3 = Job control (time 1)

4 = POS (time 1)

5 = Supervisor support (time 1)

6 = Co-worker support (time 1)

7 = Job clarity (time 1)

8 = Affective patient orientation (time 1)

9 = Work dedication (time 1)

10 = Job skills and competence (time 1)

11 = Relational performance (time 1)

12 = Functional performance (time 1)

13 = Helping behaviour (time 1)

14 = Continuous improvement (time 1)

15 = In-role performance (time 1)

16 = Discretionary performance (time 1))

17 = Overall performance (time 1))

18 = Job satisfaction (time 2)

19 = Emotional exhaustion (time 2)

20 = Positive affect (relative) (time 2)

Correlations: + $p < 0.10$, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The second point concerns the relationship between the individual difference variables at time 1 and the wellbeing variables at time 2. Once again, the correlations here are all in the expected direction (negative for emotional exhaustion and positive for both job satisfaction and relative positive affect).

The final point concerns the relationship between the patient care performance measures at time 1 and the wellbeing variables at time 2. As can be seen, the pattern of correlations here is generally weaker and more uneven. The clearest relationship is that between in-role performance and job satisfaction ($r = 0.19, p < 0.01$) and, to a lesser extent, that between in-role performance and relative positive affect ($r = 0.26, p < 0.05$). In both cases the correlations are positive, suggesting that higher in-role performance at time 1 tends to be associated with higher job satisfaction and positive affect at time 2. The remaining performance-wellbeing correlations, however, are either much weaker or non-significant.

8.4 Test of hypotheses

To test the hypotheses about the antecedents of employee wellbeing we regressed each of the wellbeing variables at time 2 separately on the combined set of time 1 JD-R and individual difference variables in our model. In this first set of analyses the performance variables at time 1 were not included as predictors of wellbeing at time 2 both because of the high intercorrelation between the different performance measures themselves (see Table 21), and in order to limit the number of predictors in the regressions. The results of the first set of regressions, excluding the performance variables, are shown in the top panel (panel (a)) of Table 21.

Table 21. Test of hypotheses: Factors affecting employee wellbeing (Time 1 → Time 2)

Panel (a): Main analysis results

Variables	Job satisfaction (Time 2)	Emotional Exhaustion (Time 2)	Relative Positive Affect (Time 2)
<i>Controls</i>			
Supervisory responsibility	.058	.047	-.071
<i>JD-R Variables</i>			
Job demands	-.227**	.456***	-.164

Job control	-0.019	-0.098	.055
POS	.047	-.129	.189*
Supervisor support	.171*	-.196**	.042
CO-worker support	.013	-.083*	.114*
Job clarity	.177	.044	.105+
<i>Individual Variables</i>			
Affective patient orientation	-.058	.045	.046
Work dedication	.418**	-.106*	.246*
Job skills and competence	-.026	-.143**	.128
R²	.380***	.460***	.376***
(N)	(122)	(122)	(122)

Panel (b): Results for performance variables

Variables	Job satisfaction	Emotional Exhaustion	Relative Positive Affect (Time 2)
	(Time 2)	(Time 2)	
Relational performance	.100	-.081	.170+
Functional performance	-.039	.040	-.045
Helping behaviour	-.087	.153	-.085
Continuous improvement	-.106	.066	-.038
In-role performance	.030	-.016	.062

Discretionary performance	-0.123+	.122	-.071
Overall performance	-.034	.004	.039

Standardised estimates: + p < 0.10, * p < 0.05, ** p < 0.01, *** p < 0.001

In a second step, we examined the effect of each of the performance variables separately on the three wellbeing variables. To do this we conducted separate regressions for each of the wellbeing variables, each time adding to the standard set of JD-R and individual difference variables a different performance measure as a predictor in the analysis. The results of this second set of analyses are shown in the bottom panel (panel (b)) of Table 21. To save space and simplify the presentation of the results, only the standardised estimates for each of the performance variables included in the various regressions are shown in panel (b). The results for the JD-R and the individual difference variables from these regressions are available from the authors upon request. It is worth noting, however, that the results for the JD-R and individual difference variables from the regressions that include the performance measures as predictors of wellbeing are virtually the same as the results of the main analysis excluding the performance variables reported in panel (a). In other words, adding the performance variables to the analysis does not affect the results for the JD-R and individual difference variables.

Focusing first on the results in panel (a), the R² values at the bottom of the panel show that the model as a whole excluding the performance variables, performs quite well. It accounts for between 38% and 46% of the variance in the different measures of wellbeing. Taken together, the JD-R and individual difference variables have a particularly strong effect on emotional exhaustion, accounting for nearly half of the variance in this variable across time (R² = 0.46).

In terms of the individual hypotheses, the JD-R hypotheses (hypotheses 1 – 6) receive quite strong, although somewhat mixed, support. Specifically, consistent with hypothesis 1, high job demands are associated with significantly higher emotional exhaustion ($\beta = 0.456, p < 0.001$) and significantly lower job satisfaction ($\beta = -0.227, p < 0.01$), although they are not related to positive affect ($\beta = -0.164, p > 0.10$). Similarly, in line with hypothesis 4, supervisor support is associated with significantly lower exhaustion ($\beta = -0.196, p < 0.01$) and significantly higher job satisfaction ($\beta = 0.171, p < 0.05$), but is not related to positive affect ($\beta = 0.042, p > 0.10$). Finally, in line with hypothesis 5, co-worker support is significantly negatively related to exhaustion ($\beta = -0.83, p < 0.05$) and significantly positively related to positive affect ($\beta = 0.114, p < 0.05$), but is not associated with job satisfaction ($\beta = 0.013, p > 0.10$). In contrast, POS is significantly positively associated only with positive affect ($\beta = 0.189, p <$

0.05), thereby providing only partial support for hypothesis 3. Finally, once the influence of all other factors is taken into account, role clarity only has a marginal positive influence on wellbeing (β for positive affect = 0.105, $p < 0.10$), while job control does not have a significant effect on any of the wellbeing variables.

The three individual difference hypotheses (hypotheses 7 - 9) also receive quite strong but uneven support in the analysis. Specifically, work dedication emerges as a key antecedent of wellbeing. Consistent with hypothesis 8, high work dedication is associated with significantly lower levels of emotional exhaustion ($\beta = -0.106$, $p < 0.05$), combined with significantly higher levels of job satisfaction ($\beta = 0.418$, $p < 0.001$) and of positive affect ($\beta = 0.246$, $p < 0.05$). Employee skills and job competence are also associated with more positive wellbeing. However, the link here is only with lower exhaustion ($\beta = -0.143$, $p < 0.01$), thereby providing only partial support for hypothesis 9. Finally, once all other influences are taken into account, an affective patient orientation does not appear to be related to any of the wellbeing variables, thereby failing to support hypothesis 7.

In terms of the impact of patient care performance on wellbeing, the results in panel (b) of Table 21 show that, except for a weak positive relationship between relational performance and positive affect ($\beta = 0.170$, $p < 0.10$) and a weak negative relationship between overall discretionary performance and job satisfaction (standardised estimate = -0.123 , $p < 0.10$), none of the performance measures at time 1 are significantly related to any of the wellbeing variables at time 2. In other words, once the influence of various JD-R and individual difference variables is taken into account, there does not appear to be any link between wellbeing and past performance on the job. More generally, therefore, the present findings, when combined with the findings from the previous chapter, suggest that the direction of causality is from wellbeing to performance, rather than the other way around. In other words, our results suggest that employee wellbeing is best seen as an antecedent rather than a consequence of patient care performance.

In summary, the results of the multivariate analysis suggest that the wellbeing of employees is importantly affected by both the quality of their experiences at work and by key individual characteristics and orientations. In terms of work experiences, job demands and social support emerge as particularly important predictors of various aspects of wellbeing. The effects involved are all in line with theoretical arguments and generally suggest that high quantitative job demands have an adverse effect on wellbeing, while high levels of social support tend to contribute to better wellbeing. In addition, the results suggest that high levels of work dedication tend to be associated with greater wellbeing, with high levels of job skills and competence also helping to contribute to a greater sense of wellbeing at work. Finally, high levels of either in-role or discretionary patient care performance at one point in time do not appear to result in either higher or

lower levels of wellbeing at a subsequent point in time. If anything, the results from this and the previous chapter suggest that the direction of the relationship is from wellbeing to performance, with greater wellbeing tending to contribute to better performance, rather than the other way around.

8.5 Additional analyses

As in the previous chapter, we conducted a series of additional analyses to check the robustness of the results of the main analysis. Specifically, we performed two additional analyses, the first to check the effects of positive bias in the panel sample, and the second to explore key interactions in the data. The results of these additional analyses, which are reported in Appendix 23, suggest that the results of the main antecedents analysis are not likely to be affected by the positive bias in the panel sample, thereby increasing confidence in the validity and generalisability of our findings concerning the antecedents of wellbeing. At the same time, the results of the additional interaction analyses suggest that in order to gain a fuller understanding of employee wellbeing it is important to consider the effect of job demands and resources simultaneously and conjointly since, to an extent, wellbeing is affected by the complex interplay between these two sets of antecedents.

8.6 Discussion

In this chapter we used the panel data covering 122 direct contact employees to examine the antecedents of employee wellbeing at work. Drawing on and extending JD-R and COR theory arguments (see Chapter 2), we first presented an overall model of the antecedents of wellbeing covering three main sets of factors: job demands and resources linked to key employee experiences at work, personal resources linked to individual employee characteristics and work orientations, and past job performance. We then tested this model using our two-wave panel data.

The results of the main analysis appear quite robust and direct attention to a number of key points concerning the antecedents of employee wellbeing. The first point concerns the relative importance of the different hypothesised antecedents of wellbeing. The results indicate that, in line with JD-R and COR theory and research, job demands and job resources, in the form of various forms of support at work, have a strong effect on wellbeing. High quantitative job demands, as expected, have a marked adverse effect on wellbeing. In particular, they are associated with significantly higher levels of exhaustion, as well as with reduced job satisfaction. In contrast social support from supervisors, co-workers and the organisation more generally, tends to have a positive effect on wellbeing in that it helps to reduce exhaustion, while at the same time enhancing satisfaction and relative positive affect at work.

In addition, the results of the main analysis indicate that wellbeing is importantly associated with the individual difference variables. In particular, work dedication is consistently positively associated with higher levels of wellbeing, including lower exhaustion and higher job satisfaction and relative positive affect. High job skills and competence are also important in that they help to reduce or minimise emotional exhaustion.

In contrast, our results provide no support to the idea that high levels of in-role or discretionary job performance have either a positive or a negative effect on wellbeing by, for example, resulting in either higher levels of job satisfaction or of emotional exhaustion at a subsequent point in time. Taken together with the findings from the previous chapter, in fact, the results of the present analysis strongly suggest that employee wellbeing is best thought of as an antecedent, rather than as a consequence, of patient care performance.

The other main points to emerge from the present analysis are linked to key interaction effects between job demands and various resource variables in our model (see Appendix 23). In particular, our findings show that particular combinations of demands and resources can have a significant influence on wellbeing above and beyond the independent effect that each of these factors has on wellbeing. Specifically, key positive work experiences or job resources, such as high levels of job control, as well as key personal resources, such as high levels of job skills, can help significantly to cushion the negative effects of high job demands on wellbeing by dampening the adverse effects of high demands on exhaustion. In other words, high resources of various kinds can help individuals to cope more effectively with high levels of quantitative job demands, thereby buffering them from the worst adverse effects of intense demands at work. By the same token, however, the interaction results also show that high job demands can significantly dampen, if not completely neutralise, the positive effect of some job and personal resources (e.g. supervisor and co-worker support, and work dedication and job skills) on the positive aspects of wellbeing (i.e. job satisfaction and relative positive affect). In other words, although high job and personal resources of various kinds can significantly contribute to key aspects of wellbeing, they are more likely to do so in situations where job demands are less intense. Specifically, when quantitative job demands are very high, high job and personal resources have a generally more limited positive effect on job satisfaction and positive affect.

Taken together the above findings have important implications for the management of front-line staff in health organisations. In particular, they direct attention to three key points linked to employee wellbeing. First, is the importance of systematically monitoring and, if necessary, controlling levels of quantitative job demands as a key way, in particular, of containing and reducing levels of exhaustion amongst employees. Second, is the need to maximise key job resources linked to a variety of positive experiences at

work. Such positive work experiences can actively contribute to better employee wellbeing in the form, in particular, of higher job satisfaction and positive affect. Particularly important in this respect are, for example, more decentralised forms of job design that give employees higher levels of discretion and control over their job, and various forms of active support at work not only from supervisors and co-workers, but also from the organisation as a whole. Finally, is the importance of ensuring high levels of job skills and competence amongst front-line employees, as well as encouraging the development of positive work attitudes and orientations amongst the workforce as a whole. More generally, therefore, our results have clear implications not only for the design of jobs in health organisations, but also for the quality and nature of organisational and local leadership and supervision. In addition, they have important implications for the selection and induction of new employees, as well as for their continuing and systematic training, development and up-skilling once they are in post.

8.7 Conclusions

In the previous chapter we identified employee wellbeing, especially in combination with a range of situational and individual factors, as an important antecedent of both in-role and discretionary patient care performance and, therefore, as a significant factor contributing to patient welfare. In the present chapter we extended this analysis by exploring the antecedents of employee wellbeing. In line with theoretical expectations, we showed that wellbeing is importantly affected by employee experiences at work, as well as by individual skills and work orientations. In particular, we showed that wellbeing is significantly affected by job demands and by key job and personal resources, separately and in combination with each other, with important implications for core aspects of the management of front-line staff in health organisations.

9 Phase II qualitative findings: Patient experience and staff wellbeing in four of the eight clinical microsystems

9.1 An overview

In this chapter we present the in-depth case study findings for four of our eight microsystems. The four we present are the low-low and high-high in the acute and community services. That is the low performing microsystems in the low performing Trust in each of acute and community and the high performing microsystem in the high performing Trust in each of acute and community Trusts. Owing to restrictions of space it is not possible to present all eight case studies in depth, but summary findings of the other four microsystems are to be found in Appendix 24 for full details please contact Jill Maben.

9.2 Oakfield Acute Trust: Emergency Admission Unit: Public expectations, job demands and staff exhaustion: how the wider social context acts as a determinant of patient experience and staff wellbeing

Summary

This case study was sampled as a low performing microsystem in a low performing Trust. Our qualitative study of the Emergency Admissions Unit (EAU) in Oakfield Acute Trust lends further evidence to several of the hypotheses supported - or elements of the hypotheses - in chapters 7 and 8. In line with JD-R and COR theory and research, job demands and job resources, in the form of various forms of support at work, have a strong effect on wellbeing. High quantitative job demands in a microsystem like this EAU, as expected, have a marked adverse effect on wellbeing; they are associated with significantly higher levels of exhaustion, as well as with reduced job satisfaction. In addition, changes in the wider social context impacted upon several key aspects of staff wellbeing and patient experience, highlighting the importance of considering how antecedents of both are significantly influenced by factors beyond organisational or team boundaries and individual characteristics.

Other variables outside of the model we described in chapters 7 and 8 also influenced the staff-patient relationship in this microsystem. Firstly, the wider social context of heightened consumer expectations - i.e. patients increasingly seeing themselves as 'consumers' of a service with certain

rights (but, as staff frequently observed, not always attendant responsibilities) - and other social changes (for example, rising rates of substance misuse and mental health conditions) serve to exacerbate very short-term and, at times, tense encounters between staff and patients. Secondly, staff interviewees consistently referred to the changing nature and content of nurse education and training as a contributory factor to the seemingly low level of 'basic' nursing skills amongst more recently qualified staff. Thirdly, there is an important distinction to be made between the wellbeing of staff and experiences of patients in (a) the EAU and (b) the physically co-located short stay ward which we include as part of this microsystem; our qualitative data indicates subtle differences in terms of the nature of the staff-patient relationship in these two settings.

Nonetheless, a combination of the broader and in-service antecedents of staff wellbeing described above - plus the nature of the typical 'encounter' between staff and patients in an emergency setting - combined to the effect that the healthcare delivered in the EAU largely focused on functional rather than relational aspects of patient care; a distinction that patients often highlighted indirectly when asked to reflect on (and rate) their personal experiences.

Patients generally reported relatively poor experiences in the EAU in Oakfield Trust and staff themselves self-rated their own 'patient care performance' as being low (compared to patients and staff in the seven other microsystems in our study - see Section 6.4). Staff wellbeing was also low; survey respondents reporting the highest levels of emotional exhaustion in all the microsystems (2.95 in comparison to mean score of 2.69 across all eight microsystems) and the second lowest level of job satisfaction (3.59 in comparison to mean score of 3.84 across all eight microsystems). In line with theoretical expectations staff then also rated their 'work dedication', 'affective patient orientation', 'continuous improvement', 'in-role performance', 'discretionary performance' and 'overall performance' as the lowest in any of our eight microsystems (see Section 6.5). In a simplistic sense, the survey findings would also appear to confirm the 'happy staff=happy patients' (or rather 'unhappy staff=unhappy patients') hypothesis referred to in Chapter 2; however, our qualitative data highlight the complexity of the links between staff wellbeing and patient experience.

In the following sections we explore in more detail, through an analysis of our qualitative data, the relatively poor experiences of staff and patients - and the links between them - in the EAU. Our analysis suggests the level of staff wellbeing and patient experience in the EAU arose from a combination of:

- The intrinsic nature of healthcare work in an emergency setting which lends itself to a largely short-term and functional 'relationship' between staff and patients.
- The high demand/low control felt by staff in an unsupportive organisational climate.
- The impact of changes in the wider social context on the morale of staff (including heightened patient expectations and increasing numbers of frequent attenders with substance misuse and/or mental health conditions).
- The changing nature of nurse education and training.

We discuss each of these themes in more detail below.

The implications of the intrinsic nature of work in an emergency setting - patient perspective

Patients and staff had views on the intrinsic nature of the work in the emergency setting and we turn first to the patients' experience, before presenting staff perspectives.

Patients observed that individual staff members were typically polite and displayed a caring attitude in a hectic environment but there were recurring themes in the patient interviews relating to noise, the busy nature of the Unit ("like St Pancras station") and the sheer "tempo" of the work undertaken by staff in "difficult circumstances", poor communication (especially between doctors and patients) and errors/oversights at discharge, as well as some privacy issues. But the overarching theme was that all patients recognised and remarked on how overworked EAU staff, in particular, were: "they were really, really busy ... they were rushed off their feet" (090710), and "they can't be everywhere at once can they? ... they haven't got as much time for everybody as what they could have."

Relating to this last point, it was common for patients to describe the care they received as efficient but lacking in the relational aspects described in Chapter 2. For instance, a patient with a heart arrhythmia who was admitted overnight to EAU before transfer to the short-stay ward and eventual discharge observed that, "I don't think they could really spend a great deal of time in making a relationship with patients. The emphasis was on the immediate practical necessities, you know?" (080610). Other patients reinforced this view describing efficient and effective systems but a sense of having been "just processed like a pea really ... [a] pretty cold sort of experience" and, whilst having being treated with dignity and respect, reporting a "total absence" of "what the nursing profession used to be about, which was ... comforting people, and making them feel that it's alright."

A further patient with a mental health condition who was admitted to EAU and the short-stay ward for three nights following an overdose identified the 'little things' which shaped her overall experience:

"I didn't know where the bathrooms were, I didn't know how to get unhooked from the machine so I could go to the bathroom, I didn't have any toiletries with me, I didn't have anybody coming to see me immediately, things like that ... I was freezing and asked for a blanket, but they didn't bring me one ... Nobody introduced themselves to me ... I couldn't tell you anybody's name ... I didn't have anything to eat... I was in there for about three days and I didn't eat at all, but nobody noticed." 090710)

A final example of how important relational aspects of care were to patients - or rather how noticeable they were when absent - arose from a patient observing the experience of an elderly patient in the bay opposite him:

"Yeah, I remember when there was an old lady across the room from me, in sort of the EAU, and she was being sick loads, and you could see that she wasn't well. I was a bit worried about her really. No one sort of came to her and she was left there for ages with this bowl of sick, and I just felt really bad for her because I thought, you know, the last thing you want when you're poorly is to be left with a bowl of sick under your nose. She was there for ages, and she kept shouting for help, and in the end someone did come, but it was quite a long time that she was left there".

And yet despite this common refrain of a lack of empathy and attention to the relational aspects of care some patients did rate their overall experience, including such aspects, very highly. For example, a patient with a deep vein thrombosis commented:

"overall opinion - yes they did very well, they were brilliant, they were very friendly, they were informative - you couldn't ask for anything more ... there were patients coming in that were, say in their 80s or whatever, who needed more care and attention than someone like me - whether it was lifting them or whatever. They were absolutely brilliant."

Such variation was explained in many cases because many of the patients we interviewed had spent some time on both the EAU and the short-stay ward and were able to draw quite clear distinctions between their experiences on each ("[EAU] being really busy, they didn't have time to introduce themselves"); in other cases it seems that relative expectations of older and younger patients played an important part in determining overall reactions to patient experiences with older patients expressing higher levels of gratitude ("I haven't been in hospital for probably about 20 years, so things have changed. They seem to be more aware of people's needs, which

made you feel a little bit special”). Staff also spoke of differences between generations of patients: “Though I find the older generation are still pretty much a joy to treat. It’s possibly the younger people that are more demanding”; “you have a lot of younger service users that are ... there is a lot going on socially and a lot of sort of behavioural problems, and it’s very frustrating to deal with”. But, overall, the nature of the relationship between staff and patients did seem qualitatively different on the short-stay ward as compared to the EAU in most cases as illustrated by the following patient and then senior staff observations:

“I did observe a young, what they used to call auxiliaries in my day, nurse, and an old lady couldn’t feed herself. Honestly, I was moved to tears. This young auxiliary nurse fed her, and was chatting away to her in such a lovely, lovely way. The old lady wasn’t speaking much, but they were having a really nice conversation ... They just seemed to have the time to deal with patients individually, which was wonderful. It actually moved me to tears. It was so lovely ... just watching this young woman, just how she dealt so beautifully with this old lady who was in a great deal of pain”.

“EAU, I would say the patient experience is probably not very good. It’s very busy, they have blood tests done, they wait around for hours and then everything happens in a flurry. They get shifted about down to X-ray and shifted back again. If they come in at night, it’s too noisy really, I think, for them to get any sleep. All the lights are on and constant admissions through the night. So I would say that it’s a difficult environment for patients on here. The short stay ward is much more settled. It’s a nice, bright ward. The nurses are very good on there, and I would say the patient experience on that ward is probably quite good.”

The importance of relational aspects of care is, of course, not limited to patients; an EAU consultant spoke of being made to ‘feel happy’ through interactions with a ‘delightful’ 95-year old female patient with whom they had ‘such a pleasant conversation [and who] looked so fantastic.’ A staff nurse on the short-stay ward spoke of “one of the most favourite things I do is if you perhaps come on duty and a patient has come in who is in really a bad state physically and perhaps needs a really good wash, and I really enjoy kind of going in and getting them washed and changed and clean and comfortable ... Kind of basic nursing care”. A nursing assistant spoke of gaining personal satisfaction ‘to know that they’re nice and clean and it gives them the start of the day I think ... I just like that bit, I just know that I’ve done my job properly. Especially when it’s a little lady say of 90 years old and she can’t do much for herself.’ Commonly, however, staff contrasted the opportunities to build relationships between EAU and the

neighbouring short-stay ward with the former being seen as offering very little opportunity in this regard:

"With it being short stay sometimes you can get patients that are here for say a couple of hours or maybe a couple of days and then you get patients that sometimes are here for two or three weeks, sometimes longer. So you do get to know them by name, you get to know their husbands, their wives and their grandchildren when they come in and it is nice, it's quite rewarding."

Some staff on the short-staff ward verbalised the differences between the two areas in stark terms when discussing being moved to EAU to cover staff shortages there: 'we're being used and abused and we're being pulled to cover next door all the time. You get a sense of trepidation. People come on duty thinking, 'Oh, am I going to be sent to EAU?' ... and so they start being scared to come to work.' Hence for some nursing staff, 'You either like working on EAU or you don't' and those nursing staff that had worked on the EAU but 'haven't coped' and subsequently gone to work on the short-stay ward were perceived as a 'weak EAU nurse that has to go to Alex because they can't cope with EAU.'

On rare occasions staff also spoke of 'overstepping the mark' in their relationships with patients. One consultant had given a personal mobile telephone number to a young patient who s/he very much identified with - "I liked her. She made me laugh" - and whom because of her social circumstances was difficult to contact, saying 'If you're poorly, ring it'; then the patient would text the consultant who would reply with a text such as 'If you're ill, go to your GP or A&E' or 'Can you come to clinic on Monday?' The doctor concerned commented that on reflection this was 'obviously inappropriate', 'a boundary had been crossed there', and that s/he would not exchange mobile telephone numbers with a patient again. The management of staff/boundaries is an issue we return to and focus on in our haemato-oncology microsystem.

The implications of the intrinsic nature of work in an emergency setting – staff perspective

Staff certainly recognised that the nature of the EAU was not always conducive to forming positive relationships with patients - *"the nature of the Unit is that it is very busy and very noisy, very fast and I think that can sometimes give the patients a bad experience"* - and they were also very clear that the nature of healthcare delivered in an emergency setting like the EAU did typically attract a particular type of nurse even if it did bring its own particular demands and stressors:

"It's the not having the same patients day in day out; I couldn't work on a ward where you turn up for work every day knowing that you've got Mrs X in the corner who's going to need a bed bath, that would

drive me insane. I'm just not that kind of nurse, every nurse is different."

*"I would definitely miss the buzz of working in an acute environment and having a direct effect, a positive effect, on patients' wellbeing and making people better ... half of the patients that we see we make a massive difference to their health. We stop them arresting. And it's not being dramatic, we really do ... half the patients are oblivious to what you've done and they're more bothered about, 'They haven't even offered me a **** cup of tea for five hours...' and you think, 'Oh, my, if only you knew'."*

One particular aspect of working in the EAU was the relative frequency with which staff encountered rude, aggressive and even violent patients. Over half of EAU staff (56.5% n=26), who responded to the staff survey at time 1 reported experiencing physical violence at work from patients in the last 12 months and 10% (n=5) from relatives and three staff (6.5%) experienced violence at work by other members of the public. These last two - relative and members of the public was the highest amongst any of our microsystems, whilst only Medicine for the Elderly experienced a higher rate of patient violence, primarily from patients with dementia or delirium. One consultant described how s/he had been head-butted twice during their career (on both occasions by women) and a Band 6 nurse practitioner observed that individual staff were able to manage - and cope with - such incidents to varying degrees:

"We get quite a lot of abusive patients. I had one about three days ago that was really swearing quite nastily at me because I'd said he was nil by mouth, and he was an alcoholic so obviously he had underlying problems. He was at me, but I just said, 'I'm not prepared to take that language. Either you stop swearing at me, or I won't look after you,' and so he didn't actually stop. But we get that quite regularly. I'm okay with it because I'm quite thick-skinned, I have learnt to deal with it, but I think it's quite hard for younger staff, the verbal abuse that we do get on a regular basis."

Another staff nurse described a more serious incident in the EAU where a Polish patient (a recovering alcoholic who did not understand English) wanted a cigarette and removed all his drips and canulas and "went tearing down the bays" before beginning to swing a drip stand around in a bay with eight frail elderly female patients and tipping the tea trolley over. Eventually the staff were able to restrain him but the staff nurse observed that, "we were lucky that day".

Just prior to our fieldwork there had been a similar incident on the short-stay ward when a member of staff was attacked, the first such incident on the ward in 12 years, and this has had an impact on the team as a whole:

"It was a healthcare support worker with a gentleman with an alcohol addiction ... He'd had his tea, had been fine, and this particular healthcare support worker was in the bay on her own, there were only three patients in that bay, and he just flew across the room and attacked her. One of the other patients went to her rescue and shouted for help, and obviously everybody turned up to help, but it really frightened that healthcare support worker, and really – well, she's needed counselling and medication, she's got post-traumatic stress... I think it's affected the team quite badly to know that... she's such a lovely person ... it's hard to believe that anybody took particular offence of her. So it's really affected everybody quite badly."

Unsurprisingly such incidents (albeit uncommon) and the more common verbal abuse experienced by staff contribute to relatively high levels of emotional exhaustion (the EAU saw the highest self-reported levels in any of our eight microsystems): "I don't want to be doing this sort of job in Emergency Care, on the shop floor, because I just don't see how you can keep going, keep going, keep going". Staff spoke about the unremitting pace and nature of their work and its impact in terms of low morale and a high sickness/absence rate ("this job ruins your health"; "never been so ill since I started this job"). Although their experiences at work were punctuated with more serious incidents such as those described above, it was also the day-to-day rudeness experienced by staff that some individuals found challenging to deal with (although others seemed better able to compartmentalise such negative experiences and not let them effect them to the same extent):

"When you've got patients that are quite rude ... Especially when you've had it all day or you could have three or four patients and sometimes when they're in the bay together they can chat amongst themselves and it's like a bit of a gang and you go in there and you're getting grief from all angles. Yeah, sometimes you do, you get days I think ... I don't think I've ever got to that point because I just take it in my stride and work's work and when I'm at home that's my home life."

The high demand/low control felt by staff in an unsupportive organisational climate

Staff highlighted how external demands on the EAU and short-stay ward - often caused by bed shortages in the remainder of the Trust or by performance targets such as the maximum four-hour trolley wait - would pressure staff to discharge patients who were not clinically ready to go home. One nurse described the case of a female patient from the previous week who, although 'it was blindingly obvious that she wasn't going to cope at home', was discharged but following irate telephone calls firstly from the patients daughter and then from her GP was readmitted the same day; "We'd discharged her in the morning and she was back in A&E in the

evening". Another nurse commented that 'you can't expect a little elderly 85 year old to understand why they need to be moved at a quarter to three in the morning ...', but increasing activity levels combined with constant pressures for greater efficiencies led to nurses, and often relatively junior nurses, turning 'these patients around far quicker than we did years ago ... and often with what feels to be less resources.' With relatively high sickness/absence rates it was also common for EAU to be short-staffed which 'If a bay is heavy, if you've got poorly patients, and then you've got admissions coming in and you're a member of staff down, that can be very stressful.'

Staff implied they had little control over their workload and felt at the mercy of whatever was happening elsewhere in the hospital, particularly in terms of the types of patients being admitted through Accident & Emergency:

"What would add stress was if I've already got a heavy bay, ...and then you get the admission sheet telling you that you've got another confused patient, or a particularly poorly patient on the way up from A&E and you think, 'Oh, , how am I going to deal with that as well as everything else that's going on?'"

Often such stresses would eventually manifest themselves in poor relations between different staff groups, for example between nursing assistants and registered nurses. As one nursing assistant put it:

"We do get cross with them sometimes because it's like, 'Can you just...?' and you think, 'Well, we're equally as busy as you are, can you not just go and run that patient to the toilet?' They seem to forget that they are still able to take the patient to the toilet. They can still give a patient a wash. They can still lend a hand making a bed ... we're running around like headless chickens, and you just think it would be nice for them to come along and say, 'Is there anything we can do for you today?' At the end of the day, it is for the benefit of the patient. They're taking one job off us, but at the end of the day, that patient may get their bed made a bit quicker, or they may get taken to the toilet a little bit quicker, and that's what we're here for." [NA on registered nurses]

A Band 6 nurse practitioner described how patient experiences should be in the EAU but then explained how factors beyond the control of EAU staff intervened to make the patient experience less than it should be:

"I'd like to think here that as soon as people arrive that they're made to feel warm and welcomed and given some food and drink at least, at the very least if they're able to... and I do think that happens. But equally there are times where it is so busy and everyone is so pushed and literally... and you're turning the beds around as quick as you can and you're mopping, and then A&E will turn up with a patient and give an appalling hand-over and they'll put them in a dirty bed, and it's

obvious it's dirty and you're thinking, 'Why haven't you let me clean it?' and it's just awful ... some people get so caught up in being stressed ... some people just can't cope and they don't always remember that actually there's a little old lady there that is poorly and scared and vulnerable and just wants probably a friendly face to say, 'Hello, you'll be alright, we'll look after you' ... You have poor care complaints and bad experiences from both the nursing and the patient side, because nurses then don't enjoy being here, it's awful sometimes ... and you feel awful ..."

Such sentiments are consistent with JD-R findings that suggest both positive and negative aspects of wellbeing are directly related to key work experiences including, for example, perceived job demands, job control, social support, role ambiguity, role conflict and distributive justice (28, 30, 31). Our qualitative findings also lend support to the stream of theorising which suggests that wellbeing is likely to be lowest in job situations characterised by a combination of high job demands and low levels of resources of various kinds.

As suggested by our staff survey compounding this sense of lack of control amongst the nursing staff in the EAU was a reported lack of 'positive organisational support' (2.56 in comparison to mean score of 2.97 across all eight microsystems) and a poor 'organisational climate' for patient-centred care (3.12 in comparison to mean score of 3.51 across all eight microsystems; this mean organisational climate score for EAU was significantly different from five of the other microsystems). This latter variable refers to the extent to which staff perceive the organisation, through its policies and practices, and through the behaviour of its managers and supervisors, to emphasise and give priority to high quality patient care. The ward sister described *'doing a full thirteen hour shift extra on top of everything else – and they've got families, they've got husbands, they've got lives outside work'* but that the Trust was not very good at thanking and rewarding such staff: *'on the whole I don't think that people always feel that valued from the more senior level'*.

'Consumer as king': patient expectations of healthcare 'encounters' and staff wellbeing

Staff frequently described how patients - mirroring wider social forces of 'consumerism' - were increasingly behaving as 'customers' of a service which they were paying for, and consequently becoming more vocal in terms of their rights and having their expectations met (regardless of clinical priority). Staff saw a correlation between this change in behaviours and a rise in complaints which impacted on staff morale:

" ... everybody knowing their rights and threatening to complain ... I've never had a complaint against me ever. They're starting to come through now, and I think that's definitely a change in behaviour. It's so time consuming. It will take me hours to answer these complaints

... In a way, the trouble is with patients is they don't know what's good medical care and what's bad medical care."

"a young girl came in on Monday. She was relatively well but she's got some ongoing sort of gastro problems and she was pregnant. Only twenty weeks pregnant, only young, but she didn't need to be in a side room, and has some problems with anxiety, is on antidepressants... and somebody, somewhere, had told her that when she came here she would have a side room and that it wouldn't be a problem: they had promised her. So she came in. When it comes to it the nurse said, 'Oh no, there's no side room'. She point blank refused to stay in if she couldn't get a side room, and got quite upset and everything and I took her out of the bay and we did put her into a clinical room but we explained to her that she couldn't stay there for the night, however she could have her assessment and everything done there. And again she refused to let us do anything, to even let us take her blood pressure until we'd sorted out a side room for her ... I nicely explained to the lady that I totally appreciated that she had anxiety and panic attacks and that it was something to be taken seriously and that it was awful, however I couldn't get her a side room ... And her mother just wouldn't get it, and was saying that I was dismissing her daughter's mental health problems, and that her mental health problems were just as important if not more important still than if someone was having a bit of diarrhoea and I tried to explain to her that actually no, because if we put someone with diarrhoea in the middle of a bay that could infect everybody and the staff and then they'll carry it and so on... and she just wouldn't have it, completely wouldn't have it ... that was two hours of my time just sorting it out and her Mum still wasn't happy."

However, nursing staff did acknowledge that some complaints were justified:

"... some of the complaints again you'll find you can pin back to very basic stuff and you just cringe and think, 'Oh, they must think nurses are animals, they just leave people in wet beds and nobody would do that'. Nobody, unless they were actually sick, would think, 'Oh do you know what, we'll leave it, I don't want to go and clean it', nobody would. We're not in the job to treat people like that, but sometimes those basic things mean everything to a patient and there is a problem and they don't get done, and it isn't acceptable really, is it?"

A second significant social change was the rise in patients attending (and commonly frequently re-attending) the EAU with substance abuse and/or mental health problems, or from socially disadvantaged and marginalized groups. This changing profile of patients combined with the rise of consumerism described above served to create a real sense of frustration amongst some nursing staff as to the demands being placed - in their view unfairly - upon them by such patients:

".. if you look at the vast majority of people that we particularly see, it's people with addiction, it's a lot of unemployed patients, certain social groups with a lack of education... that's only increasing. You know, more and more people are out of work and that's only ever increasing. Immigration too, we've got more and more people from abroad moving here and using our service ... and I find all that very frustrating and the most frustrating thing is public expectation. They come here and expect everything immediately."

Staff felt that whilst some patients were quick to voice and exercise their rights to healthcare (and to complain without delay if their expectations were not met) they were much less ready to accept any responsibility for their personal health or behaviour:

"They take no responsibility for their own health ... there is no sense of responsibility, they don't take any responsibility for their own health care and this is being very general but a large number of patients I feel that I see have no concept of what they're getting, how much the little things that they are getting, such as a nurse, such as an X-ray, a bed overnight, how much that actually costs. And how much we've had cut and taken away from us, and the targets and pressures that we're under. And I don't know how long that can continue, and I don't really want to be a part of it."

One Band 6 nurse practitioner related a recent experience where there were six relatives around one bed space, laughing loudly, and two young children running around making lots of noise and the patient was eating some fast food on the bed. Next to this bed was a frail, old lady but when the nurse asked the group if they would mind just keeping their noise down or perhaps moving to the visitor's room as there should really only be two relatives around a bed at any time, she was told to '**** off'. Similarly, a consultant spoke of a 22-year-old girl s/he had seen the previous week and then seen again the morning of our interview who had 'ruined my day'; the doctor described how s/he had walked on the ward, seen the girl's name, could immediately 'feel my morale disappearing as I approached her'. The girl's behaviour was very confrontational as the doctor refused to give in to her demands for morphine. The doctor spoke of feeling 'unsatisfied because I can see no end to her inpatient stay, and so I didn't get any further forward with her care, particularly, so I've not made her better and I've not got her any nearer to discharge.'

Changing nature of nurse education and training

A final broader influence on the nature of patient experience on this EAU that was commonly cited by more senior nurses and other healthcare staff was how nurse education and training had changed significantly over the last two decades:

"you find that the older nurses, ones that have trained probably 20 years ago, are the ones that are a bit more forward and say, 'Well, I

can give you a hand with this bed.' You get a lot of the newly qualified nurses, it's like, 'Well, I've been to university. I've got these blue epaulets, and I don't have to take the patient to the toilet anymore.'"

"They're not taught the basic things about how to look after a patient. I mean, they come to us and they've never put a catheter in, they've never done any actual manual and essential skills. They've only done them on paper, whereas in our day, we had to be physically seen to do it. It's alright doing it theoretically, but then in practice, it's a whole different ballgame."

Older staff gave examples of nursing assistants who during their three years before qualifying would not interrupt a patient whilst they were eating or having a wash but then, once 'they get that white uniform on with blue epaulets their common sense goes out of the window'. Recent graduate nurses were characterised as being 'more interested in perhaps the documentation side of things, doing the more glamorous side of things than the fundamental aspects'. Some interviewees were more scathing: "I think a lot of them don't think they should be hands-on if they're a staff nurse. They basically think that they're there just to do the drugs and look pretty, basically. "The implication of the 'academic nursing degree' was that newly qualified nurses were not always equipped with the skills to understand and empathise with a patient and 'provide them with dignity, privacy, and all those issues'. Lacking in these skills could be a root cause of poor patient experiences:

"A lot of issues I've had recently are around the newly qualified staff nurses, and it's just sometimes the way they've spoken to a patient or a relative, and what they're saying is factually true, but it's just the way it's delivered. And that is just lack of experience. Sometimes you have to hold your hands up and explain that to the patient and the relative and say, 'I'm very sorry that it's come across in this manner. The message that's been delivered is correct, but I understand it's caused you some concern.' Often it comes with experience ... "

Contrasting views were offered, particularly by the Band 6 nurse practitioners:

"I'm not a touchy feely hands-on nurse nurse that wants to work in a care of the elderly ward and do all that stuff, that isn't what floats my boat. I prefer the high-tech side, nurses doing more. By definition the nurse practitioner role is sort of almost like doctors on the cheap, and that's what does it for me really, being challenged mentally, and bed baths aren't mentally challenging."

9.3 Elmwick Acute Trust: Haematology Service: Managing boundaries: the importance of local climate and patient experience

Summary

This case study was sampled as a high performing microsystem in a high performing Trust. The haematology service in Elmwick Trust saw - on most quantitative measures - the highest patient experience ratings in any of our microsystems; in particular, this service scored the highest 'level of knowing' on the PEECH scale and high scores for (a) respect and dignity, (b) overall care and (c) recommending the service to friends and family. Our qualitative data provided extensive evidence to support and explain these findings. This is perhaps not surprising given the high personal investment many of the patients have in the service and the strong relationships they build up over significant periods of time with staff. The rather more intriguing aspect of this microsystem is, firstly, that staff rated their own 'patient care performance' as only average and, secondly, that staff wellbeing was the lowest of the four acute microsystems we studied (and the sixth lowest of the eight overall). So here - in what was assumed to be a 'high-performing' microsystem - we find the clearest disjunction between reportedly very high levels of patient experience but relatively low staff wellbeing.

From the staff survey findings it appears that the highest job demands (and lowest job control) in any of our microsystems were dampening the positive effect of some job and personal resource variables (for instance, staff acknowledged a high level of supervisor support), as well as contributing to the highest negative affect and very high levels of emotional exhaustion. As in the EAU microsystem described earlier these findings support COR and JD-R theories; namely that emotional exhaustion reduces individual motivation and capacity to engage in desirable in-role and discretionary behaviour at work, and that high job demands are related not only to exhaustion but also to low job satisfaction and positive affect. Our qualitative data point to the very high emotional labour demands - which are inherent in such a microsystem - that are placed on staff. Such demands require staff to actively manage their professional and personal boundaries with patients; individual staff members did this in different ways and with varying levels of 'success'.

Importantly, staff in this haematology service rated themselves as low in terms of the individual variables in our model (surprisingly so in terms of affective patient orientation and job skills given our qualitative findings) which can otherwise serve to mitigate the adverse effects of high job demands. These individual variables were also found in the survey to have by far the strongest direct effect on both in-role and discretionary patient care performance (both of which were lower in the haematology service

than in our maternity and M for E microsystems). It does appear, however, that strong organisational and, particularly, local climates that prioritised high quality patient care were substituting for staff wellbeing in the sense that they made up, to some extent, for the absence of high levels of wellbeing; thus here climate appears to be a key variable in achieving the excellent patient experience in this service, albeit perhaps at the cost of individual staff wellbeing.

Our qualitative findings point towards four key themes shaping patient experience and staff wellbeing - and the links between them - in this haematology service:

- the high levels of personal investment in the haematology service from both patients and staff
- the high levels of emotional labour and job demands placed on staff, and resulting levels of emotional exhaustion
- the relative 'success' of individual staff strategies in managing personal and professional boundaries
- the role of local 'climate' in delivering excellent patient experience.

Each of these four themes is discussed in more detail below together with a postscript highlighting clear differences in how the two inpatient wards were perceived by staff.

High levels of personal investment in the haematology service from both patients and staff

Amongst our eight microsystems an almost unique feature of the haematology service was the high levels of personal investment that patients placed in the staff and service itself. Because of the nature of the treatments they had received, many of the patients we interviewed were inpatients on one of the two wards for between 4-12 weeks and frequent attenders at the day unit thereafter (*'Sometimes they come in every day for a week, so you do get to know them, and they get to know you'*(22651)). Our interviews with patients are replete with appreciative sentiments about the care and treatment they had received over significant periods of time such as the following examples:

"the quality of care, the regularity of observation, the courtesy, dignity, and good humour of everyone, was just overwhelming; it changed my life, enhanced things. I'd rather this hadn't happened rather than had happened, but it was a turning point for me, and the outcome at the moment is very bleak but looking back, that was very positive, like a sabbatical. I was cared for, I had a beautiful room; I could relax about bodily things. I could enjoy the conversations with everyone who came in ... And that must be a sign of some nurse and staff wellbeing, if they can suspend whatever background they've come from and divert themselves to the benefit of the patient. That was just exhilarating. I

wrote a letter to the chief executive, saying how privileged I was to be a patient there". (22013)

"I just can't get over how friendly they all are, and professional at the same time. They seem to mix it together ever so well. It's almost, in my mind, if they applied to work on one of these wards, are they interviewed to see if they're that special type of person that can nurse people with these specific types of diseases? It seems in my mind they must do." (22008)

Given such sentiments it is hardly surprising that this service received the highest PEECH scores and highest 'overall' patient ratings (see Section 6.4) and consistently positive feedback ('*excellent*', '*second to none*', '*saved my life*', '*just superb*', '*totally unbelievable*') relating, firstly, to the caring and compassionate nursing staff ('*They deserve medals!*', '*can't speak too highly of them*'), and, secondly, the highly knowledgeable doctors.

One of the patients related how, after his first month in hospital, he noticed there was a form where patients could nominate a member of staff who had delivered excellent patient care. He explained how he was thinking of all the staff he had had contact with ('*from the cleaners who I have a laugh and a joke with ... to the staff who bring your food around ... they're friendly ... they just lighten your day ... to the nursing staff, to the permanent doctors there, to the consultants*') (22008) and had thought, '*How can I choose one?*'. In conversation with another patient he decided instead to nominate the whole ward. Compared to our findings in one of the acute microsystems described earlier (EAU in Oakfield Trust), patients - like the one quoted above - spoke much more positively about the relational aspects of their care:

"The little things seem to me to be some very, very simple things - that you're offered a cup of tea, you're offered a drink of water, you're offered a biscuit, you're offered a snack, you're offered a meal, by the nursing staff and the nursing assistants as well as by volunteers ... everyone's always offering you a cup of tea, a drink, and stopping for a bit of repartee. So it's a nice thing; it's just more of a human approach really". (22056)

The 'human' approach experienced in the service was not limited to just how staff interacted with patients but also how the patients grew to know each other over time, although this, naturally, had both positive and negative implications, as first a senior sister and, secondly, a patient observed:

"... they get to know each other quite well, they see each other when they're in-patients and then they see each other at out-patients and that's quite nice. We've got two guys who are at exactly the same point in their treatment and they've just literally tracked each other the whole way through. They're in competition now as to who's going to finish their chemo first, who's going to recover their counts first,

who gets away with the least amount of blood and platelets and things and they see each other out of this environment as well, their families, their wives have got very close.” (22646)

“[a patient talking about other patients] I love them, yes. And berate they’re lost. It’s unthinkable; there’s a young woman with two children, apparently she didn’t make it. I’m just devastated.” (22013)

Not only the patients but also many of the staff appeared to have a high level of personal investment in the service, often because of their own personal biography. One of the ward sisters described the appointment process for a recent health care assistant post:

“ ... one of [the interviewees] said, ‘I’ve looked after my mum, I look after blah, blah, blah, and she’s so lovely, but sometimes she gets on my nerves and I want to dink her one.’ And it was just the way she said it ... she’s here now, and the patients absolutely love her, because she’s got that level of conversation with them, and she can see what they need, that extra something ... [The patients] call it, ‘Susie love,’ the patients need a bit of Susie love, because it’s that something that you can’t quantify, you can’t say what it is ...” (22601)

Another health care assistant who had been in post for five years explained how she had come to work in the service, *‘my dad got cancer, so coming in and out of hospitals, I figured that I could do a better job, I thought I could. I took a year out to look after him, and then after he died, I thought, ‘I’m going to go and do it now’, rather than moaning. You should always try. I’ve not looked back ... Yes, it’s very rewarding. I wouldn’t go back to electronics now’ (22624)*. The notion of how rewarding it was for staff to work in the haematology service was a consistent theme in our interviews as expressed here by a Band 3 healthcare assistant:

“The patient care that you can give is better than anywhere else that I could ever imagine. It’s very, very patient orientated ... to be able to have the time to sit with somebody just to rub cream in their hands because they look a bit dry, as opposed to having to leave them until they’re washed the next day and then do it; it’s so much more rewarding; it’s what nursing is all about for me, definitely.” (22624)

“we had a lady come in, and she was really friendly - very poorly when she was admitted, newly diagnosed AML. And I really seemed to bond with her; really, she made me realise what I was supposed to do here, what people needed me to do. And over the last five years, I’ve seen her throughout all of her treatment; she had a bone marrow transplant, all different things ... And to be there with her at the end, and her family, and the way that they were so appreciative of ... me being there - made me feel that I’d achieved something really good within what I do”. (22624)

9.3.1 Emotional labour and job demands

As described in Chapter 2, staff and patient emotions are often central both to the wellbeing of the former and experiences of the latter. This is certainly the case in the setting of a haematology service where patients want staff to communicate with them effectively, to show compassion, and patience, show that they care about them and ‘connect’ with them as individual people, but also where staff have to actively manage their emotions in order to deal with the complex range of emotions engendered by the human suffering, loss, and disease manifestations they encounter. As we suggested in Chapter 2 the impact of these increased demands on staff wellbeing is largely unknown, though it is thought that estrangement as a result of emotional labour whilst an occupational hazard can also be a valuable defence against stress.

Staff in this haematology service reported the second highest level of emotional exhaustion of the microsystems we studied (2.76 in comparison to mean score of 2.69 across all eight microsystems). Several staff interviewees referred to ‘a run of four patients’ who died around Christmas (two teenagers, one young man that staff had come to know very well, and another patient who died very suddenly) as ‘quite traumatic’ (22601):

“It’s been really, really low over Christmas - really low. We had a really rough trot of losing about five young people, one a week, from Christmas Eve, and it really knocked everybody right down ... It makes you feel really frustrated, because everybody’s working really hard, and trying everything to their best, and the nature of the disease is they’re probably going to die anyway, but because they’re young, you never can accept that- never accept that they can’t get better”.
(22624)

Analysis of the interviews provided a clear sense of the emotional intensity of the work in the haematology service; often staff would highlight cases of deaths of younger patients as being particularly stressful - “*the thing that upsets myself most is when ... we’ve got a young patient who is going to die because whatever we do for them is going nowhere*” (22601); “*I can remember early on in my career waking up in the middle of the night and fretting about patients and dreaming about patients and being extremely upset when they die. I can remember that*” (22602). The service and wider Trust provided ways of enabling staff to ‘*have some time out and go and have a reflective session’ together after such patient deaths - either through the bereavement office or palliative care service - or the staff ‘bounce off each other and talk to each other’ and the ward sisters* (22626). One of the ward sisters commented that some nurses who have only been in post for a relatively short period of time can find where to draw the line very difficult; her advice was ‘*very caring when you’re at work, but then you know that they’re patients and you go home*’. She also described how the junior nurses needed ‘*a lot of support from [their] seniors*’ and how teams hold de-briefings when patients and focused particularly on staff they knew had

become attached, as well as trying to vary the patients that staff look after so that an individual nurse does not look after the same patient for two weeks constantly (320114).

Much of the heightened job demands felt by staff - and reflected in their staff wellbeing survey responses (4.18 in comparison to mean score of 4.05 across all eight microsystems) - arose from the age of the patients they were treating and the nature of their conditions which sometimes manifested itself in patients becoming aggressive (and even suicidal). Two different staff members (a senior sister and a Band 3 healthcare assistant) described reactions from patients and families that placed further demands upon them:

“very young chap who’s just recently come from paediatrics into adult services’ who was ‘just generally following staff around, screaming up and down the corridor one day because he didn’t get his own way to have something, which is very, very difficult. And other times you get a patient who is maybe dying and the family hadn’t realised that, we were at that stage, and they can be quite demanding, ‘What’s happening, why didn’t you tell us this, what’s going on, why is he dying?’” (22626)

“... the male nurse went in to speak with him, and he decided that he didn’t want him to touch him, but rather than stay there, he grabbed a pair of scissors and tried to stab his arm. Yes, that’s the only violent one that I’ve ever known. We’ve had aggressive visitors. Visitors often get more aggressive than the patients do, but never physically threatening or anything, just more verbal ... it’s mainly frustration - and sorrow, grief.” (22624)

Staff also spoke of ever increasing demands in terms of numbers of patients and the severity of their disease – *“the unit’s not big enough and we don’t have enough beds for patients who really need beds ... Everywhere is full”* (22646) and having no sense of being able to do anything to better manage or even just cope with such pressures; or their frustrations at delays in accessing treatments or services from other departments that meant *“patients sit there waiting, and you just feel awful for them”* (22651).

Another key stressor was when there were differences in opinion between nursing and medical staff in terms of when - and how long - to intervene with certain patients. As one senior sister described:

“We had a patient who died on the ward a couple of months ago and we’d been seeing him beforehand for a long, long time and then he went onto the ward and had his transplant and he died the most awful, horrible death that I’ve seen for a long time and it was really, really awful ... There was a lot of talk about this young lad and about what ... at the end it was clear that he was going to die, but as often happens in haematology, you just keep going and keep going ... I think it’s enhanced in haematology, ‘We’ll just try this, we’ll just try this’ and

it's like, 'Just go and have a look at him lying in that bed and think about what you're doing, what you're putting him through' ... I mean they kept him alive for another three weeks I should think. You think, 'This is just awful' and it was awful. He was in pain, he was bleeding, and it was just shocking ... I think there was a lot of discussions and the nurses say, 'You tell me what we're doing and what you think we can achieve by doing this?'"(22646)

Nurses spoke of seeing *'the despair in the family's faces ...'* but how *'we keep piling this stuff in'* (22601). In such cases nurses in particular would reflect upon how it was *'a little bit difficult to switch off'* (22651) but having to do so because they were conscious of how they *'came across'* to patients and *'... if you've had a bad day, you don't take it out on the people that you look after'* (22651). One senior nurse described how there was *'a lot more stress and anxiety around the palliative person, the dying person [in haematology compared to oncology generally] ... [because] the transition is a lot less clear and more painful.'* (22602)

9.3.2 Managing personal and professional boundaries

Implicit in much of the preceding analysis and quotations from staff is the question of how staff manage the 'boundaries' between their patients and themselves in ways that deliver patient-centred care (and particularly the relational aspects of that care) but without increasing the stress to themselves to unmanageable levels. As in our medicine for the elderly microsystem in the same Trust, consultants recognised that, in this regard, it *'is easier for us as doctors [compared to nurses] to come in ... because we can then walk away for several hours ... rather than have to go back in ten minutes later and change the drip'* (22659). Senior nurses spoke of years of experience of managing relationships with patients, either formally through written guidelines and, informally, through passing on their advice to more junior staff:

"we've had situations with teenagers before where people have become too friendly with patients, and they've got too involved with them, and there are specific protocols here, and guidelines here now, and I'm very keen to be aware if I feel that somebody... because what happens if they do become too friendly it always goes wrong. It always goes wrong. And people have learnt and seen mistakes that other people have made." (22601)

Without prompting from the interviewer, staff independently identified the question of whether to attend patient funerals as being a key boundary issue that needed careful managing. The service had a written protocol about staff attending funerals which specified that if they did so then it had to be in their own - not work - time. The clear advice from senior nurses was that this *'really ... is crossing the boundary ... I know myself it's not right to be getting over friendly with patients, because it just doesn't work. It always goes wrong at some point'* (22601):

“It’s the only way the nurses can do their job, is to distance yourself a little bit, otherwise they’d be breaking down all over the place. ... the longer you’ve been in the job, the easier it is to do. Obviously we all get attached to certain people, you wouldn’t be in the job if you didn’t do that, but you learn to cope with it, and learn mechanisms to deal with it ... because the patients all talk to each other, they’re quite a close-knit group, so obviously if they then know that this person died a month ago and you went to their funeral, then maybe that person’s family would expect you to do the same. And so you just can’t do it. (22626)

Different staff did have different ways of coping with deaths of patients:

“you get to know them very well over quite a long period of time and people struggle with their boundaries of how far do you take this friendship. Sometimes it goes a bit awry and people find that hard to deal with... you have different coping mechanisms to deal with that sort of thing ... One of those things is about boundaries and some people make that mistake once and they learn from it, some people make that mistake on a repeated basis and then they get hurt ... A lot of staff that I worked with used to like to go to the funerals of patients for closure, but for me, I did it once or twice and the emotion that you see at the funerals is very different from what you see on the wards and it’s, for me, that’s way over my boundary and I don’t want to have to deal with that ... If [junior nurses] say that they want to go, I’ll say, ‘That’s fine but just be very careful and watch what your boundaries are because you’ve got to come back here and look after your other patients.’ I would never stop anybody from going to a funeral because different people have different ways of achieving their closure on whatever’s happened.” (22646)

One of the consultants also discussed how they had twice in their whole career attended a patient funeral and reflected on what it was that had made those two patients somehow different: *‘it was just something about the way we had interacted or the way the family had interacted ... made me feel that that was the right thing to do in those circumstances’* (22624). However, the consultant now felt, looking back, that it was not the right thing to do. Another consultant shared this view on the basis that if staff attended the funeral of the 17-year-old that died of acute leukaemia, then they should also attend the funeral of the 90-year-old that died from anaemia; s/he felt, firstly, that staff should not differentiate between patients in that way and that, secondly, s/he did not have *‘the emotional energy to go to funerals’*. In coming to this decision s/he was following the advice *‘from one of my old mentors and they taught you these things that you’ve got to preserve yourself somehow’* (22660).

Although attending funerals was therefore seen as a relatively black and white issue with senior staff strongly advising against it, the appropriateness of day-to-day conversations was more a of a grey area;

one senior sister (22626) advised that if staff wanted to talk to patients about their holidays and what they had planned for the weekend then that was fine but if it was to say *'I've had a horrible day, such and such...'* then that was inappropriate. A Band 3 healthcare assistant similarly reflected that:

"I never speak to them about death or dying unless they want to talk about it ... about how they felt about dying, or if they were scared, or anything like that - never. If they wanted to talk about it, I'd let them mention it, but I'd never bring anything up about death or dying ... I'm very mindful not to bring any of my problems to them ... If somebody's been in here for three months, I wouldn't want to say, 'I had a lovely day at the seaside yesterday; it was lovely, the sun was shining!' I'd probably go in and have a moan to them about something my husband had done to annoy me or something, just chat in general ... I am quite mindful with saying about trips out and things, because I know obviously that they can't. Swimming is another touchy subject; I never mention swimming, because they can't with their lives." (22624)

Climate

So in this haematology service we find a combination of very highly rated and reported patient experience and yet relatively low staff wellbeing, influenced in particular by high levels of emotional labour, as well as high job demands and a low sense of job control (all leading to one of the highest levels of emotional exhaustion in our eight microsystems as described above). It appears from our staff survey results and qualitative data that the positive local - and to a lesser extent organisational - climate had a key part to play in achieving the excellent patient experience in this service.

'Climate' as measured in our staff survey and discussed further below refers to the extent to which high quality patient care is emphasised and given priority at various levels in the organisation, including staff personal perceptions of their work environment on such issues as the formal and informal policies and procedures used in the organisation (Rousseau, 1998; Schneider, 1990). In the context of this study we are particularly interested in the climate for patient care in the organisation, namely the extent to which staff perceive the organisation, through its policies and practices, and through the behaviour of its managers and supervisors, to emphasise and give priority to high quality patient care. As described in Chapter 2 and 7, a strong climate for patient care contributes to patient care performance by providing clear signals to staff about what specific patient care behaviours are expected, supported and rewarded in the organisation. In large, complex organisations, climate may well vary across organisational sub-units (such as our microsystems); hence we measured both organisational and local climate in our staff survey and the results – together with our qualitative data - suggest a particularly strong local climate in this

haematology service (4.38 in comparison to mean score of 4.17 across all 8 microsystems).

Certainly our qualitative data suggested a very strong culture in the long established inpatient ward (of course, strong cultures can have their benefits and drawbacks – see below), with clear nursing leadership and a cohesive and experienced team, who used each other for support and debriefing:

“we’ve got a very close team here now and it’s something that I’ve built up over four years. I’m not sure how I managed it, but I’ve got a team that are very close colleagues, and their preference to deal with that is to talk to each other ...They’re very specific about what they want here. And I truly haven’t made them be like that. They know what they want - and they want to talk to their friends freely, and say whatever they want to say.” (22601)

The relatively small size of the teams on both the inpatient wards and the day unit clearly helped in this regard and this cohesiveness and sense of shared purpose at ward level was discernible to some of the patients too; one patient described their impression that many of the staff had been working together on the ward for a long time and that positive team working was a feature of their own experiences (*‘there was just a feeling that this was a good unit, this was a place that set a high standard’* (320083). One staff member put this in terms of *‘a real sense of everyone working together for the same aim’* (320109).

When probed as to with which part of the organisation they most identified, it was clear that staff on this inpatient ward had a very strong sense of loyalty to their immediate colleagues (and patients):

“it’s about the patients, you know, it is about the patients having a good time. They come in so distressed, and it’s about taking them through that, sending them off, and actually feeling that we’ve been part of making their experience so much better than what they imagined it would ever be, because it’s the worst thing in the world to be diagnosed with leukaemia. [INT: And being part of [acute trust 2] doesn’t contribute to that, it’s about the team here and...] Yeah, I know, isn’t that awful? ... my motivation and morale is about [ward] and this team, and making this the best place, the best ward in the hospital. That’s my motivation, really.” (22601)

The ‘reflection sessions and tea and coffee’ after particularly stressful or traumatising events that occurred on the ward - as described above - were highlighted as significant team building interventions *‘because we all get to sit together and cry or shout or get angry’* (22624). One of the consultants also described a culture of empowerment on both the inpatient wards and day unit that manifested itself through a *‘sense of freedom’* where staff are allowed to take the initiative and to be self organising: *‘it’s something to do*

with setting norms and expectations but then giving them enough space to get on with it' (320085).

Postscript: '... there's this stupid rivalry thing going on'

Finally, it is important to note that we were consistently alerted to a significant 'rivalry' between the two inpatient wards in the staff interviews we conducted. One consultant spoke of a '*huge, huge difference*' between the two wards from a medical staff point of view which s/he ascribed to the different styles of nursing leadership on the wards. The consultant spoke of her '*medics getting very anxious*' about working on one of the wards as it was '*very much, 'You will do what I say,' from the nursing staff*' and there was little team working between doctors and nurses ('*Even the registrars, if they're not quite strong registrars, have a tough time*'). In contrast, the junior doctors '*love it*' on the other ward because '*there's a lot of interaction and they're nice. It's a pleasure to work on [even though] it's a much harder area, because it's not such a nice environment*' (22660).

Nursing staff described the relations between the two wards as '*there's this stupid rivalry thing that seems to go on ... which reminds me of being at school*' (320109). Much of the discordance between the two inpatient wards appeared to stem from the fact that one had been established much longer than the other (and took a slightly more complex case mix). Although patients commented very favourably about staff on both wards and did not highlight any differences between them (other than the markedly better physical environment on one of the in-patient wards), staff themselves stated very clearly that the two wards had 'different atmospheres'. The impending reconfiguration of services at the end of our fieldwork meant that the more recently established ward was to close and staff were being redeployed elsewhere in the oncology directorate; we highlight this point as this news may well have had an impact on the responses to the time 2 staff surveys in this particular microsystem as it created a lot of uncertainty and unhappiness amongst nursing staff in particular at precisely the time the survey was fielded.

9.4 Ashcroft Trust: Adult Community Nursing Service (1): A Fractured Service: Dissatisfied staff, poor patient experience and selective Care

Summary

This case study was sampled as a low performing microsystem in a low performing trust. This Adult Community Nursing Service (ACNS1) in Ashcroft Trust highlighted a clear general connection between poor staff wellbeing and poor patient experience of care. Low rates of job satisfaction amongst staff in this microsystem are indicated from our survey, interview and field observation research. The microsystem study conducted here

strongly supports - as a negative example - elements of the JD-R and CO-R hypotheses. In particular the effects of high job demand and low job control due to recent - and over ambitious - service commissioning contracts are highlighted. At the same time, long standing interpersonal conflicts within teams led to low co-worker support and a poor local workgroup climate for patient care in some parts of the service. These unmanaged conflicts undermined perceptions of organisational support for staff and for patient care.

Our qualitative findings suggest that, within this fractured service, some patients received good care some of the time. Variations in patient experience of care reflected differences between patients who were liked or not liked by staff as well as patients who are likely to complain or not complain about care received. In addition some staff sought to compensate for a poor service or the poor care of some colleagues by working harder as individuals. These individuals rated their own standards of discretionary care and affective patient orientation rather than the standards of the service overall.

9.4.1 Service structure and reputation

All operational managers noted the difficulties of both recruiting and retaining staff (and the particular shortage of experienced registered and district nurses within this service). They explained these staff recruitment and retention challenges as the product of a range of pressures that were external to this service. They noted the national shortfalls in district nurse training or training recruitment along with the declining attraction of community work to qualified nurses. More particularly they noted the outer-city location of this organisation which meant that nurses could earn significantly more doing the same job in an adjoining organisation only a few miles closer to the city.

The staff survey, with albeit limited responses for this service, showed a pattern of very recent and very long established staff in this service (20% of staff in post had worked in the organisation for less than one year and 23% of staff had worked in the organisation for more than 15 years). The limited engagement of staff in the staff survey (n= 30) in Ashcroft (community nursing service¹) suggests that these findings should be treated with caution.

Staff interviews indicated that community nursing staff tended to remain in the same service throughout their employment in the organisation. One senior manager's description of the staffing profile within the service reflected these findings; s/he described a service

"with old timers who stick there through thick and thin... have done battles and continue here.. and other staff who come, train and pass through" (Head of Patient Safety and Patient Experience).

Clinical managers had a more nuanced view of the reasons for chronic staffing difficulties. They noted chronic work stress amongst longer established as well as more recently recruited staff. In line with these observations of clinical managers the staff survey indicated high levels of negative affect and emotional exhaustion amongst survey respondents. Job satisfaction was reported as lower in this microsystem than in all other community and acute microsystems and this microsystem had the highest rates of emotional exhaustion of all community microsystems (matched only by the haemato-oncology service and an accident and emergency service in the acute microsystems).

Several managers and staff interviewees noted the effects of repeated reorganisation of the community nursing service on staff wellbeing and work satisfaction in recent years. For example a community matron in one of the better performing locality area described the effects of the "long haul" to recovery after every service realignment (she remembered four realignments in the ten or so years that she had worked in this service). She estimated that such realignments took front-line community nursing teams about eighteen months to two years to recover. She described the effects of the recent "wave of change" on her teams: it had left them "exhausted and tearful everyday.. with new workloads, new patients, new addresses and new colleagues" (600).

Many clinical managers interviewed noted that longer established staff had found the introduction of performance management into the service especially challenging and demoralising, particularly in a situation of a chronic shortage of experienced community nursing staff. Two nurse consultants and two service managers (who both left the service during the research period) complained bitterly about the effects on the ongoing service commissioning contract that was for each staff member to complete between 10 and 13 patient home visits a day (irrespective of indirect patient contact work and patient referral work). This service provider/commissioner contract, with its high job demand and low job control for front-line nursing staff was felt to be unreasonable by all clinical managers and all front-line nursing staff. Staff noted that this contract failed to take account of the varied immediate clinical needs of each patient and failed to allow staff time to manage the ongoing needs of patients (to communicate with one another and with other services).

It was significant, then, that the staff survey rated the organisational climate for patient care at Ashcroft as low but not the lowest within the community or the acute microsystems. However staff rated the perceived organisational support for their job as the lowest of all the eight microsystems. In addition, staff rated local/workgroup climate for patient

care in this Ashcroft service was the lowest of the eight microsystems (rated 3.82 with the next lowest rating, in one acute service, as 4.05).

Indeed, the poor regard of staff for the service, rather than organisational, climate for patient care was also reflected in some managers and some staffs' discussions about the limited capacity of the service (and, often, some senior personnel within the service) to make the most of often generous organisational investments in staff and their patient care practices.

Many staff perceived the use of organisational investments in staff training within this service to be ineffective. For example, several staff complained that although they were able to attend specialist clinical skills training, there was never the staff capacity within the service to allow them time to consolidate these skills (607;613;702;708). In addition, some clinical managers noted some progressive improvement of clinical care within some areas of the service following intensive and ongoing organisational investments in clinical and 'values and behaviours' training of front-line staff. However they also noted the limited effects of such training investments on changing established attitudes and working practices amongst some team leaders within the service.

All operational and clinical managers, as well as some front-line staff, noted the lasting harm of poor reputation (within and beyond the organisation) upon this service. Two nurse consultants involved in recent service improvement initiatives were dismayed by the lack of confidence and depth of resentment and disengagement of front-line staff (who felt "always dumped on" and "treated like rubbish"). Operational and clinical managers were also concerned about the tendency of some community nursing staff to discuss their feelings about the service with staff outside of the organisation, for example primary care staff.

During the period of fieldwork in this service, service managers and senior clinical staff were working to recruit and train a new generation of community nursing staff to the organisation with overseas recruitment initiatives as well as generous offers of pre-qualifying (leading to qualifying) training bursaries. These initiatives met with varied success. Field observations indicate that those staff newly recruited through these schemes only remained working in this service, or enthusiastic in their work or work opportunities, if they were placed in better performing teams and localities within the service. These new recruits also often faced resentment by longer serving colleagues who felt that they had forfeited their own entitlements to training opportunities and, more significant, skills consolidation. Within less than a year many of the best new recruits had 'fast tracked' into other services or left the organisation.

9.4.2 Patient experience

The patient survey findings of the PEECH patient survey - adapted for use in community health services - indicated that patient experience within this

service was the poorest for all eight (acute and community) microsystems. Patient rating of patient experience was also lowest for all four aspects of PEECH. Nevertheless some patient interviews and field observations indicated that care was not consistently poor for all patients within the service or for all patient-staff encounters in the same parts of the service. The following sections examine the qualitative research findings in more detail and highlight those aspects of poor patient experience that were most significant for patients in community nursing services.

Due to the limited organisational structures to support patient experience survey data collection the patient (n=10) survey findings should be treated with caution.

"They all seem so busy but..." (31011)

With notable exceptions patient experience of care in this service was poor. The exceptions to this were patients who were cared for by day staff in one of the six locality clusters and some individuals who were cared for by some staff in the other locality clusters (see discussion below).

One patient volunteered her observations on the difference between "getting looked after" and having "good care" (31005). Also, apart from one younger patient with long standing and complex care needs all patients described a service where staff were too busy "doing their job" which means "things like injections" (31011; 31008; 31009) and "looking after people who are dying" (31008) to "do many things" (31011), to "talk to me" (31008) or to "do more than a task" (31019). All older patients mentioned feelings of discomfort and guilt during nurses' visits, some felt "like a nuisance" (31005) particularly that they "took up the nurses' time" (31011). Taking up the nurse's time included being unable to answer their front door or find their patient record as quickly as the nurse would like and asking the nurse questions about their care. One elderly woman, a former senior radiographer in a busy London hospital, who required daily nurse visits, commented:

"I just don't want to make their job more difficult.. they are the ones coming and going and I feel that I'm just sitting here like a lady.. I do feel very bad about that" (310016).

Another elderly patient remembered nurses' complaints to her that they had been called to "do another job after this one [that is, as she understood it, to visit another patient after her]". She felt uncomfortable or worried "as they will then turn around and start on me" (31011).

While patients recognised that the nurses were busy they also sometimes indicated that there was something in some nurses' manner that made them feel more uncomfortable, anxious or insecure. Many patients indicated, often indirectly, that 'busyness' was not always sufficient reason for poor patient experience. These patients were aware of marked differences in the quality of care given by different individual staff. Indeed,

all patients were able to associate some poor care experiences with the same individual nurses.

Overall, patients most common experiences of poor care can be categorised under three key concerns: timeliness; consistency and friendliness. The following paragraphs examine each of these in turn.

9.4.3 Timely care

Although all patients and carers understood that staff had "a list of people to see" (31006; 31008) and many assumed that staff had to deal some emergency calls, they also described the ongoing effects of unpredictable home visits on their everyday lives. For example, the elderly and exhausted wife and sole carer of a patient with dementia and diabetes told of the consequences of nurses arriving as late as 10.00 pm to give her husband's insulin injection. Following this visit she always cooked for her husband, helped him to eat, bathed him and helped him to bed. This carer told the researcher that she had explained her situation several times to the nursing staff however their immediate response to her concern as well as efforts to schedule an earlier patient visit had varied greatly between individual staff. This carer also noted that some earlier day time visits were possibly for some nurses almost every day and were never possible for other nurses. Her conclusion was that some nurses "just don't care" (31000).

The anxiety caused by late and missed visits was generally underestimated by community nursing staff, who often felt this to be a groundless reason for patient comment or complaint. The particular visiting needs of some individual patients, and particularly the needs of frail elderly patients, were often overlooked. For example the elderly widow and former radiographer who required daily dressings for an uncomfortable facial wound was partially deaf and lived alone. She described the "nerve wracking daily wait" for a nurse, who might not arrive until late afternoon. During this time she could not use her garden, call friends or move far around the house in case she missed the 'one ring' on the door bell. She had explained these difficulties to several staff but she had insufficient trust in the nurses to recognise and accommodate for her disability. No patient could understand why staff were unable to notify them of a significant delay (as was the practice in the parallel community nursing service in Larchmere organisation). Also, few staff could understand why their late arrival at patients' homes should bother those who were largely housebound.

9.4.4 Inconsistent clinical care

Patients were anxious when they received treatment from staff who appeared unaware of their clinical condition or their clinical care needs. For example one patient noted that: "they don't seem to "follow through what has gone before" (31006) and "it's as if they are reading the book [patient held record] and they still don't seem to know" (31006).

One middle-aged patient who had received community nursing care twice daily for several years observed “they don’t seem to talk before they leave the office.. there seems to be no forward planning...they spend all their time on phones sorting out shifts and don’t [talk] a lot about patients” (31008).

One patient, a middle aged man with complex nursing care needs and extensive patient experience, observed the poor clinical practice of many staff within the service that, he felt, compromised both his care and staff safety. He described how nurses hurried to complete his leg dressings and so stooped over him rather than knelt down. He knew that this practice led to health risks for staff as well as less comfortable or secure dressings for him.

Two patients and two carers described how they had learned to ask questions from the more approachable staff so that they were able to give clear instructions for their treatment to both new staff and to established staff who seemed to lack clinical knowledge (in dressings; wound cleaning; the administration of injections and clinical observation work).

Fieldwork observations confirmed the emotional distress caused to carers and patients when staff offered conflicting advice and treatments. This was particularly the case when staff offered different advice to carers on the boundaries between patient care, family care and self-care for frail elderly patients with complex and ongoing clinical care needs. Additionally, field observations indicated that the same patients often received different information on long term care and treatment goals and on patient referral planning from one nurse to the next. One carer commented to the researcher ‘I never know how to cope with who is coming through the door everyday and telling me a different [thing], which is which and what is what’ (31008).

Fieldwork observations were also made of some nursing staff who explained patients’ and carers’ confusions over care and information as the fault of patients and carers who “are worried so they don’t listen properly” (702) or “are just seeing how far they can go with us” (706). The researcher observed one particularly worrying incident when a staff nurse reassured an elderly and confused man that she would personally return the next day to inform him of his care plans even though she knew that she would not be at work the next day.

9.4.5 Unfriendly care

Patients regularly emphasised the importance of friendly nurses (and often talked of rude, abrupt and sullen nurses). Friendliness was important to patients for many different reasons: it was sometimes just about a nurse “being chatty, because this is the only person I’ll see today” (31011) however carers and patients also valued the skills of a nurse who could “pick up on things” while they chatted (31017) or “wriggle concerns out of you” (31009). Most patients with more limited care needs appreciated nurses who were approachable and showed this by “just asking how you are

doing" (31008). However patients and carers of patients with more complex or pressing care needs were sometimes wary that staff friendliness was not an expression of genuine concern. These patients and carers were dubious of a service or of nursing staff who were unable to respond to their care needs in more concrete and useful ways (31005; 31000; 31017). Several patients also noted that they felt most comfortable and at ease with staff who they knew "can do a decent [clinical] job" (31001).

"The nurses you know treat you better.." (31009)

All patients in those service areas (localities) where patient experience was poorest had few expectations of being told the name or position of any nurse caring for them even though these patients said that they would have appreciated this. Several patients receiving regular and long term care commented that they never knew any of the nurses but "eventually the same one comes back round again" (31016).

As indicated above, patients interviewed in this service were critically aware of an overlap between clinical skills and caring behaviours. Many felt that one skill complemented the other. This felt relationship between receiving care from a known nurse and improved patient experience was complex and multifaceted. Observations indicated that some staff who knew patients better were more willing or able to accommodate patient's changing circumstances, "to fit in a little bit" around the patient (31011). One carer commented: "I know the times when they were going to turn up, what they were going to do, how they are going to do it... mutual understanding makes a big difference" (31005).

Also, patients enjoyed not having to explain care or treatment routines at every nurse visit (which could be twice in a single day). Also patients felt that some staff who visited them more often "get to know how you like it done" (31016). Observations of the performance of treatment routines can be mutually satisfying experience for those who gave and who received care. Three patients noted that 'known staff' (unlike unknown staff) did not hurt them when they gave injections, "because they know how I like it" (31009) or cleaned and dressed wounds "because there are some really tricky bits and it's hard to explain this to them all the time" (31001).

Known staff were also valued because patients could find topics to chat about more easily: "it's easier [to talk] when you know bits about each other" (31018). While some patients felt that nursing staff should make an effort to form a relationship with them, some more experienced patients felt that this would only ever come about from their own 'staff care' work: "you have to be careful and considerate... if you don't nag you are more likely to give you [what you need]" (31005). Some established patients formed wider reciprocal ties with some individual staff (such as advising on computing or local services) that contributed to the sense of "working together" (31008).

"...and there are good ones and bad ones.." (31005)

As in the Elmwick service M for E, patients were aware of the often stark contrasts in the behaviours of different nurses. All patients interviewed considered these differences to be a matter of the individual nurse rather than service or organisational responsibility. Also, several patients discussed these individual differences in relation to two, often overlapping, categories.

First, patients noted the contrasts between regular staff and agency staff with most of the latter "in it for the money.. no care or consideration [and] ..probably paid on the basis of numbers" (31005). All patients receiving weekend care identified the majority of staff as agency and most noted poorer patient and clinical care at weekends.

Second, several patients equated agency staff with "foreign staff" (31005; 31006; 31008; 31009; 31011) and complained of being unable to understand spoken accents. Thus the elderly patient and former radiographer with hearing difficulties commented that the issue was not that she couldn't understand the nursing staff but that they "aren't bothered that she didn't" (31009). One patient described evening visits from two evening staff who "ganged up on" her by purposely talking in a language that she could not understand their conversation (31008).

9.4.6 Staff wellbeing

As noted above, job satisfaction in this microsystem was the lowest of all the eight microsystems. In addition, this staff survey response highlighted the felt poverty of the local/work-group climate (also rated the lowest of all the eight microsystems) and of felt co-worker support (also rated the lowest of all the eight microsystems). The survey also suggests a connection between an impoverished local/workgroup climate and team working tendencies. In the staff survey over 36% of respondents reported that they do not work in a team with clear objectives (the highest percentage response of all eight microsystems). Also 20% of respondents felt that they did not work with other team members to achieve team objectives (also the highest percentage response of all eight microsystems).

The discussion below examines the interconnections between high job demands and low job control experienced by staff in this service as well as how these effects on impoverished staff wellbeing are exacerbated by the felt effects of poor clinical practice and team and locality leadership within pockets of the service.

"There are too many unreasonable expectations..." (31702)

At interview and during fieldwork observations nursing staff in some localities listed a multitude of factors that caused them to feel miserable at work. They listed a range of extra-organisational factors that included uncertainties over work and pensions with the TCS agenda; difficulties with managing the Electronic Patient Record System due to either lack of time or skills (leading to worries over clinical error) and poorly co-ordinated patient

transfers. They also listed inter-organisational factors. For the most part, staff unhappiness centred on the unreasonable demands of the current commissioning contract (see above). Field observations indicated that, with the important exception of one service locality (see below), a shared sense of 'not enough time to care' pervaded this nursing service. Staff felt that "contact numbers [not] complexity of care" now defined community nursing work (706;702;608). One staff member noted her difficulty in "telling patients what we cannot do for them" (607) and another mentioned her guilt at having to offer poor professional care (she also remarked on the effects of a Centralised Patient Referral System which prevented her from being able to negotiate care needs directly with patients (706).

Many staff repeatedly noted to the researcher, and to one another, that "we only have 10 minutes per patient". They said this irrespective of the fluctuating calls on their time during and over different shifts and during different home visits (which sometimes took them less than 5 minutes). Observations of morning and evening 'handovers' indicated nursing concerns with only immediate functional care needs because of felt lack of time⁸. In addition, both qualified and unqualified staff described a situation to the researcher where "the matrons and Band 6s just can't cope with the work load" (613). They described examples of matrons "getting over 200 emails a day" and of district nurses facing a six month backlog of patient referrals into the patient continence service within this organisation.

Some significant antecedents and dimensions of poor staff wellbeing identified in staff interviews and in observation fieldwork were also evident in the staff survey findings. Most notably, staff in this service reported a low rate of felt job control (the lowest rates of the eight microsystems) and a high rate of job demand (the highest of the four community microsystems).

At the same time, however, staff interview and observational fieldwork indicated that not all staff were equally affected by a lack of these JD-R antecedents to staff wellbeing. At interview not all staff were similarly dissatisfied or disaffected at work. All staff who were less dissatisfied with their jobs, or even enjoyed their work, worked in the same locality and these staff described the importance of good locality management; supervisor support and co-worker support to them. Two staff working here described the importance of "working out ways to get a hold on what you are doing" (600; 606). Their experience indicated the significance of local/work-group climate to mitigate increasing job demand by allowing staff to assert some degree of job control.

Of particular interest to this study is the way that different staff sought to manage or mitigate the felt effects of unreasonable job demand in other parts of this community service.

⁸ The researcher was not encouraged to observe patient 'handovers' during afternoon office times which, she was assured, were more thorough than morning or evening handovers.

Interview data indicates that staff tended to manage felt excessive job demand at the expense of patient care. Thus at interview staff explained that “lower priority ones can be cancelled for the EPRS” (702); that “they [patients] just have to wait” (712) and “[patients] have to realise our limits” (706). During observation fieldwork some staff who spoke of their stress or disillusionment at work became especially irritable and confrontational with patients, and particularly with elderly and frail patients and carers who lacked the skills or confidence to become more ‘self-caring’. These patients were sometimes reminded that they were taking nurses’ time away from others who were more sick or dying.

A few more insightful nurses confided to the field observer that it was sometimes worth “thinking about patients” (anon) because it made their work easier in the long run. At interview some staff also explained that taking time to notify patients of delays and cancellations, to apologise for a short or delayed visit, or to treat patients politely saved work time as they would not have to deal with distressed patients, complaining relatives or formal complaints (702; 608; 607; 706). The consequence of this view of patient care was clear during field observations. These observations were of staff attending carefully to the requests of patients or relatives who became upset or who often called them if they were unhappy about the timing of a home visit or the quality of care. In effect, these staff attended more carefully to more articulate and assertive patients and families, sometimes at the expense of other patients.

“..some staff are a nightmare to work with....” (613)

Interviews with managers and all staff; some observational fieldwork and staff survey findings indicated some very poor working relationships between particular individuals or groups of staff within and across some parts of the service (notably three of the nine service areas). One acting service manager commented that he “had never seen anything like it... people just clawing at one another” (750). He noted that staff’s regular preoccupation with taking out formal complaints and grievances about one another (colleagues within their own team) was an ongoing distraction from patient care discussions and planning. However interviews with front-line staff within these service areas indicated that staff as often took out complaints about colleagues who they felt delivered poor nursing care (or placed patients at clinical risk). All staff interviewed noted that those teams or localities where nursing practice was known to be unsafe – “where you risked your PIN” (702; 706) – were also the teams where interpersonal conflict between staff was greatest.

Staff survey results indicate that, across the service, co-worker support was rated lower than in any of the other eight microsystems.

All staff interviewed (except for two individuals) were very critical of the care behaviours and clinical practices of two or three particular Band 6 and 7 staff (607;613;702;706;708;608). These interviewees also noted that

these individuals were exploitative or unsupportive of their teams and were known to blame them for their own clinical errors. Field observations and interviews with patients (many of whom were keen for the researcher to identify staff through their patient held records) indicated that these particular staff were associated with particularly poor patient care events. In addition all interviewees and field observation participants listed those particular localities or teams where they refused to work because of poor leadership. They also noted that these localities and teams were sites with the lowest staff retention rates within the service⁹. Overall, the wider effect of a sustained pocket of poor nurse leadership and poor clinical practice upon patient experience, as well as on staff wellbeing in this service, was far reaching and multifaceted. Six consequences were identified within this microsystem.

First, and most immediately, staff who felt mistreated by team leaders or matrons went sick, sometimes for several weeks at a time, with "depression", "stress" or "nerves" (608;706;750).

Second, a wider body of staff felt angry with service managers who appeared to fail to protect staff as well as patients from negligent colleagues. For example one team leader suspected that at least one of the episodes of poor clinical care by a Band 6 was due to an occupational health problem. She was critical of a service that failed to attend to this possibility and monitor this event as a health and safety issue. Additionally, many staff were highly critical of service employment practices that allowed already poorly performing nursing staff to extend their working hours into bank working and so become more exhausted.

Third, many staff had grown distrustful of a service that did not seem interested in protect them or their patients. Some staff felt that managers were "only interested in running the service, not how it is run" (720). Others reckoned that poor clinical practices were tolerated because of longstanding relationships of friendship between some staff and some service managers. In addition, many staff were deeply cynical of service and of organisational HR systems available for reporting poor working practices and poor patient care behaviours. Staff and some managers recounted complex scenarios of complaints and counter complaint or of grievance and counter grievance that simply gridlocked the system. Some staff felt that other staff and some team leaders protected themselves from criticism or investigation by "playing the race card" (702) or using a written warning "just when you don't like someone" (706).

Fourth, and less directly, the felt ineffectivity of the service or the organisation to hear or to protect staff who felt compromised by difficult colleagues led to a more general sense of vulnerability amongst front-line

⁹ In this service, as in the adult community nursing service in Larchmere, staff were contacted to the service rather than to particular localities or teams. Service Heads were known to move staff from better performing to poorer performing services as staff left the latter.

staff. Staff felt unheard and unprotected by their service more generally and this feeling sometimes spilled into staffs' attitudes to patients and patient care. An example of this effect is the ongoing concern of staff for their personal safety during home visits to patients. Although the service had invested in measures to protect staff during out-of-hours visits (with staff 'double up' arrangements for all evening and night as well as the phased introduction of lone working safety devices) staff continued to feel that their service managers could not or would not act effectively to protect them from abusive or threatening patient behaviours (702;720). Thus one community nurse explained that she now always dealt with rudeness and racism by patients herself and without bothering to report such events to the service. She explained how she dealt with such patient behaviours: "I will be off with a disrespectful patient but I will still do my job... I treat my patients well if they treat me well" (608).

Finally, and in the longer term, staff left the service because they were miserable at work. Although organisational managers explained poor staff retention in terms of demographic pressures external to the organisation or the service, all staff interviewed insisted that their colleagues had left the service to avoid work placements in the poorly performing teams or localities. Several staff interviewees who were working their notices before leaving this service said that they had taken equivalent work for lower payment in an adjoining organisation. Difficulties with staff recruitment left some service areas heavily reliant on agency staff. Even in the best performing areas of the service senior clinical staff noted the 'nightmare' of working with agency staff who were costly, might leave without notice and were not given paid time to liaise with colleagues. Agency staff carried a reputation for being less interested in the service or in delivering good patient care.

The contagious quality of poor workplace practices within teams was illustrated by a poignant informal conversation with one matron during fieldwork observations. The matron recalled how she had been treated by her service manager several years previously. Following a catalogue of personal misfortunes and minor professional errors her manager had threatened and finally initiated a formal complaint about her professional practice as well as a formal grievance about her behaviour towards her at work. During these complex proceedings this matron was promoted into a more senior clinical management role. She now managed her staff teams by a similar strategy of threats of written warnings; complaints and personal grievance proceedings. At the same time this matron appeared to be exhausted and alienated from her staff, many of whom she felt "were always difficult" or "gone bad" (750).

"..but I still manage to care for patients" (613)

A notable aspect of this service is the marked discrepancy between patients' poor care experience (also indicated by PEECH survey as the poorest

experience of all eight microsystems) and staffs' own assessment of the quality of care they offered.

In the staff survey staff rated themselves highly for affective patient orientation (highest of all eight microsystems) and high for discretionary patient helping behaviours.

This disconnection between nurses' and patients' views on patient experience appears to be the product of a remarkably fractured service where staff held dissonant or conflicting views on what constituted good patient care behaviours. Also, instead of staff assessing the care that their patients experienced in this service as a whole, staff focused more on assessing the care that they individually delivered to patients. Thus several nurses felt very positive about their work with patients and especially enjoyed visiting patients who "are always pleased to see me because [I am] not the other staff" (702). Several nurses interviewed described how they "put [themselves] out" (601) to offer good care and "take on a few extra things for patients" (608) because they wanted to compensate for the poor care offered to these patients by their colleagues.

It is notable, then, that although several staff interviewed felt that they managed to compensate for the poor practices of some of their colleagues, patients themselves more often recounted (and particularly in the survey) a general experience of impoverished emotional care from across a spread of encounters with staff.

9.5 Adult Community Nursing Service (2) Larchmere: "Feeling Known": the relationship between organisational resourcing, local climates of staff support and co-working to support a practical ethic of good patient care

Summary

This case study was sampled as a high performing microsystem in a high performing Trust. This Adult Community Nursing Service (ACNS2) in Larchmere Trust, with its consistently high survey scores for patient experience of emotional care and for staff wellbeing, offers an example of the advantages of tangible organisational resourcing to support staff wellbeing. More specifically it illustrates the importance of a local/workgroup environment to both support staff wellbeing and a shared ethic of patient care. This microsystem study offers support for these significant elements of the JD-R model and for COR theory. However it also indicates that, in front-line health care work, staff organised both effective co-worker and team relationships through a shared view of the purpose of their work and through valuing patient care. The study shows that an ethic of care that is sustained and given

legitimacy in co-working relationships can operate as either a rhetorical device or a practical underpinning to staff behaviours that enhance patient experience of care. Staff survey ratings for this microsystem indicated work experience of high job control (where this microsystem scored highest of all eight microsystems) as well as lower job clarity (even though this service scored higher than any other community microsystem). In the context of this microsystem, this tendency might be explained by the confusions resulting from the historical overlap between community nursing work and primary care services work.

The microsystem study demonstrates the significance of local/workgroup support for staff wellbeing with the context of sufficient organisational resourcing for community nursing work. The quantitative data indicates a clear connection between staff wellbeing and patient experience and the qualitative data examines how relationships of co-working are central to both staff wellbeing; a vibrant ethic of patient care; and the practical knowledge of patient care and patients as people. This microsystem study suggests that both front-line patient care work and staff experience is influenced by wider extra-organisational social demographics. In this microsystem many working relationships and patient care relationships developed in communities that were stable and long established. However the qualitative research illustrates how nursing staff exploited this situation using care skills in ways that effectively met the emotional care needs of patients.

9.5.1 Locality, service and organisational identification

This service locality was recommended to the research team by the Head of Service and several other clinical and operational managers who knew that these particular community nursing teams were stable and, from local survey findings, that patient satisfaction was good¹⁰. Some managers explained this trend in this service to be the outcome of different community demographics (the locality was presumed to have a reduced incidence of poverty and social issues). By contrast, the locality manager was keen to involve clinical teams in the research because of a sense that this service and this locality in particular “often feels forgotten for the work they do” (640). The manager felt that staff (with whom s/he had worked as a Band 6 until the previous year) were outstanding in the care that they delivered to patients and that this achievement was not well recognised within the service or the organisation.

¹⁰ ‘Listening to Your Views’ annual survey (distributed to patients by staff) estimated 40% response rate¹⁰

In the service area most nursing team office bases are situated close to their GP patient catchment areas and were up to 16 kilometres apart from one another (average return car journey time of 40 minutes). However regular, well attended and friendly 'Band 6 meetings'; the rotation of Band 6s through the locality evening service and assistance with Band 6 inductions; the longevity of staff relationships and the feeling of shared locality and shared locality management led all teams in this microsystem to view themselves as both distinctive and better performing than the service more generally. Staff noted (and other managers also noted) that in other locality areas there was greater staff stress due to some disruptive personalities, staff retention issues, poorer locality management and patients with more complex social and illness needs.

A notable aspect of work identity for staff in this service area is their felt distance from their wider service as well as the wider provider services organisation (and former PCT).

The organisation (case study site 4) is distinctive of the two community provider services case studies for its strategic emphasis on staff engagement and consultation for service innovation. Within the adult community nursing service, in particular, the service head emphasised the value of consistent and committed front-line staff representation and engagement work. The example she gave was of 'link activities' initiated to develop streams of community health service work (including the 'Patient Dignity' and 'Patient Safety' agendas). In this work staff from the various community nursing teams were encouraged to attend regular afternoon meetings; to participate in these developments as well as to feed-back to their team colleagues. Also, through the research period, this emphasis on staff engagement was enhanced due to the (DoH) recommended staff consultation activities surrounding the unfolding TCS agenda.

In the service locality where fieldwork was conducted all staff did participate in some of these staff engagement initiatives, using nominated team or shared team representatives to feed back between organisational and local office meetings. Fieldwork observations and informal conversations with staff indicated that staff were more enthusiastic about engagement activities that might impact on service improvement for their patients than consultation activities that might affect their own working lives. Additionally, observations of the office feedback events indicated that almost all staff (including some team leaders) were deeply cynical of the purpose and likely outcomes of these events. They felt that this work was "management inspired" (620), "out of touch" (624) and "just more box ticking" (625).

Additionally, staff felt that they were barely known to managers and did not know the managers. For example, in two teams in particular, front-line staff said that they knew nothing of any managers beyond locality management staff and the name of their head of service (whom many had not met). They supposed that this was because these managers 'all kept

moving around so much'. They did, however, know the name and role of one senior nurse manager and they agreed that they liked her and thought her work useful. It was this manager who "actually came out to us to talk about things a year or so ago" (602). The details of organisational engagement arrangements upset many staff and disclosed, they felt, an organisational agenda that they opposed. For example several staff noted that most engagement activities were booked in meeting rooms that took time for all staff teams to travel to but that were always located close to managers' offices (indicating, to them, that management time was more important than 'patient time'). During the fieldwork period another event sent ripples of irritation through the teams arranged to visit a team leader and arrived over 30 minutes late, and without apology or an advance call explaining this delay. As staff interpreted this event, the manager had caused the team leader to leave her patients early and compromise 'proper' nursing work for less important management affairs.

In all, across the service locality, nursing staff and staff teams were highly cynical of the purpose of the organisation and the activities of managers. The exception was their view of their immediate locality managers, and former colleague who was valued because he "knows what you mean" (601); "doesn't step back all the time" (609) and "isn't like us and them" (606).

Generally, staff felt that the purpose and likely effects of organisationally directed service reform detracted from the 'real' purpose' of their work which was, staff constantly reminded themselves and the researcher, "to put patient care [patients] first" (620; 601; 605; 620; 623; 613; 624).

Given these frequent observations during fieldwork - that staff felt cynical towards organisational innovation work- it is interesting to contrast the findings of the microsystem staff survey (where staff rated perceived organisational support for their work as well as felt organisational support as well as felt local-workgroup support for patient care amongst the highest of all eight microsystems. As noted above, and following the JD-R and COR theory, staff valued certain organisational resources that they felt enabled them to continue with their front-line patient care work. These were, notably, tangible resources such as sustained staff numbers and specialist clinical training rather than the less tangible and longer term staff and patient benefits of staff engagement activities.

9.5.2 Patient experience

"I get the personal touch because they know me" (41034)

The PEECH survey adapted for this community microsystem shows that patients scored many aspects of their emotional care (notably levels of felt connection, security and personal value) higher than for any other microsystem. In all, however, due to the limited organisational structures to support patient experience survey data collection the small numbers of patient (n=34) survey findings should be treated with caution.

Also interview and field observation research indicates that the most notable dimension of good patient experience in this service is that patients felt known by staff. The idea of 'being known' led patients and carers to speak of nursing staff in very appreciative and often moving terms: "I feel that I can talk to them. I feel part and parcel of it all when the nurses come.. they talk to [me] so that [I] feel part of what they are doing.. they know that that's very important for me" (012a); "it's not like a stranger coming it [but] like a friend I can talk to" (021c); "they feel like family" (012d); "it's like [when they come in] they look at me and just know how things have been here.. and that makes a real difference" (010). Patients had different views on how, and in what circumstances, this sense of being known by the nurses was fostered. For the most part (and with some important exceptions) patients considered that 'being known' by the nurses happened because the nurses were simply friendly or caring people or naturally dedicated to others (or their patients).

In this community health service demographic factors and care skills and activities (involving staff and patients) contributed to this crucial patient sense of 'being known'.

9.5.3 Demographic factors

Patient populations were stable over time. This stability affected patient experiences of care in two particular ways.

First, patients (and others) actively shared their opinions of the service with regular neighbours and local family. Eight of the patients interviewed noted to the researcher that "our district nursing service" had a "wonderful reputation". This service was a source of local pride to both patients and to staff.

Second, patients were often cared for by staff who already knew them. As people moved in and out of this service, as patients or relatives (see discussion below) they came to "get that rapport" [with staff] (012c). As indicated above, staff teams were stable over time. In addition, town and rural communities within this locality were generally close knit, with longer established staff sometimes sharing diffuse or more direct relationships with patients that extended beyond immediate care delivery settings. For example, in one town within the service locality some staff and several patients attended the same church and social events. Across the service locality as a whole (and during the field research) six of the 29 staff had some longstanding friendship or family relationship to at least one patient that they themselves or their team were caring for.

The effects of good service reputation as well as of close social connections to service staff need not, of course, always be positive to patients. As one patient and his wife (whose son was dating a community staff nurse employed in another locality team) half-joked, "of course they are all great, what else would we be allowed to say about her?" (056). However many

patients were highly critical of other local health services, which also employed friends, relatives and neighbours.

As discussed in more detail below, these demographic factors were not, in themselves, sufficient for patients to feel 'known' by staff. In addition field observations and patient interviews suggest that it was sometimes the case that patients' experiences of 'being known' had an illusionary quality but that, nevertheless, contributed to a positive emotional experience of care. For example one long term patient explained that "the staff are a bit different now.. some are in the service longer than others .. but wherever they come from I feel that I know them" (012a). Additionally, as discussed below, skilful staff were able to 'work the idea' of familiarity to enhance the comfort of patients. For example staff who were 'new to a patient' could draw on what they already knew of patients' particularities, 'in-jokes' or interests to ease change and sustain a sense of ongoing care.

9.5.4 Staff skills: Knowledge and instrumental practice

Given that staff on this microsystem rated their relational in-role and discretionary care behaviours highly, it is surprising that individual staff rated their skills and competence in patient care less highly. This might be because staff felt less adequately equipped to manage community patients with increasingly complex care needs, but also because staff might not be aware of their competencies in relational care work.

Perhaps to the credit of staff, patients did not often recognise the particular skills employed by staff to 'chat' to patients and to make them feel 'known'. From the perspective of most patients and carers, and particularly elderly or more socially isolated or dependent, staff "knowing them" was a 'natural' outcome of caring personalities or natural affinities between ordinary people.

Field observations suggest that patients' sense of being known by individual staff often hinged on a quick (staff led) identification of a few small and common points of social connection on first visit. This was followed by a more mutual and ongoing return-reference to any common points of personal interest. These common points of interest were especially valued by patients if they were extraneous to, but did not undermine, their immediate care needs. Thus a visiting nurse would often identify and, in subsequent visits return to, an interest that she shares with a particular patient (for example, in dogs; breakfast; cake decorating; or a television programme) or a shared experience (for example, finding a lost cardigan; a shared joke; or family detail) or known family detail). Different visiting nurses often established their own particular repertoires of common interest with these same patients. These ordinary but personalised 'points of reference' often enabled patients, and particularly the elderly or confused, to identify staff, as well as to feel known and remembered, by these staff. Additionally, through the everyday and always active interest that staff in this service locality had in their patients' lives, they were able to sustain

shared repertoires of little details about patients' lives that newly visiting staff could draw upon to ease the awkwardness of first visits or felt absence.

A few patients and carers were aware that establishing a few common threads of social interest with individual staff also involved effort on the part of patients. Thus one middle aged woman with complex medical needs explained that "sharing experiences with staff is important for patients" (012d) and outlined what she knew of the staff who had regularly visited her until four months previously (she knew who had fallen over where though the snowy winter months; family and pet bereavements; children's whereabouts, employment and wedding plans). This way, she advised, "you can build a picture of what they are doing.. training, children, how far away they travel from and things like that.. and that all makes a big difference to how I feel and how we all get along" (012d). Another younger patient who had banked into this approach wholeheartedly (when she receives daily nurse visits for a three month period) could recount the names, personal interests and breed of dog owned by every staff member who had visited. She simply explained that that "it's fun chatting to different people when you are stuck indoors.. they're company" (034). This patient considered that she knew every member of nursing staff in the locality "very, very well" because she 'liked chatting'. When the researcher visited her after the home, when these visits had been reduced to one a month, this woman felt bereft.

A dimension of patient experience rarely acknowledged by patients as individuals, and sometimes a challenge to staff, is the variability of patient expectations of relational care. For example some patients expressed a preference for staff "to do the job and the pleasantries" (036) or "just come in to do a job and go" (010). In these situations staff's work of relational care remained "a bit of banter" (010; 033) or "just doing the chat" (012c) or "a natter while they're doing the foot" (012e).

The challenge for staff to meet the shifting and often unpredictable or ambivalent relational care needs of some patients and some staff were especially skilled in anticipating this. For example, one elderly and very reserved patient, a care home resident, was known by staff as often inflexible and uncooperative in his leg ulcer care. Staff often felt that he was overly critical of them and pondered the possibilities of his having OCD. The patient often remarked that all staff, not matter how kind they looked, were "imperious, telling you what they want to do with you" (011). At the same time, however, this patient worried about his reputation with the nurses: he joked "I think they send different ones to me because they have to take it in turns to see the grumpy old patient.. they draw straws in the office.. and I can see why sometimes" (011). Despite this tense situation, this elderly man was flattered by the way that a senior community nurse introduced him to the research project. He told the researcher "do you know the nurse came with you the other day and said to me "we've chose you for

this.. we've chosen you this morning" and.. that was nice...indeed, I was amazed at that" (011).

Many more senior qualified nursing staff (Senior Band 5s) and district nurses are aware of the crucial interconnections between "doing the bits" (620) (clinical care) and care of the person; they insisted to the researcher, more junior staff and student nurses placed with them that this care was always interconnected.

For example, before staff entered patients' homes they always made sure that they knew of their patients' planned clinic or hospital appointments so that they could remind them of dates and check transport arrangements. Other times, staff noted that they could 'pick up on problems' when they visited patients they knew better and these same patients noted that "you can't get away with anything with them [the nurses]" (034). During several observed occasions of routine wound care experienced staff read the subtle changes in patients' mobility, discomfort or pain by their particular and sometimes very idiosyncratic facial or vocal expressions. These signs went unnoticed by the researcher and other staff who did not know the patients so well.

Team Knowledge and the Accommodation of Patients

A further aspect of this general emphasis by patients on the importance of "being known" by staff is that it sometimes served as a device for patients (and sometimes staff) to accommodate less acceptable behaviours from patients or carers. Thus one patient explained her behaviour towards a Band 6 nurse who was trying to persuade her to attend an urgent hospital appointment: "I called her a ***** and she just laughed and said I've been called worse than that .. she just got on with her job and took the clinical decision.. she sort of knows me now... what I can be like.." (033).

For a different staff team, and during the course of the field observation work, the idea of 'knowing' and so accommodating a carer became an important explanatory framework to sustain staff's involvement and positive feeling towards the family care of a dying patient. This team were providing end-of-life care for a woman whose husband's behaviour had become unpredictable and sometimes hostile towards visiting nurses. The district nurse who led this team repeatedly reminded her staff that 'we know that this isn't really him' (601). In this case 'knowing the carer' provided the rationale for staff to sustain empathic care and to sustain a relationship with this man with the support of their wider nursing team.

"The staff went out of their way..." (032)

Staff sometimes cared for patients who were widows of their former patients. In these situations both individual staff and patients emphasised the special bond and memories that united them. Staff exploited these coincidences to improve the relational care of these patients (even though staff themselves did not view that these behaviours as in role or

discretionary 'work'). Not infrequently patients especially remembered the care that individual staff had shown, particularly when this care was felt to be sincere, that is, (as one patient considered it) "doing more than you have to do" (033). For example one patient described how during a visit to the GPs surgery two years previously, one of the staff nurses had gone out of her way to greet her and to offer her condolences following the death of her husband (a former patient of this nurses' team). This widow explained "that was a great feeling.. because they remembered me" (047). This act had, in many respects, defined this patient's view of all staff in the locality service.

"You just have to give a ring and they shoot right in here" (010)

A second notable aspect of patient experience is the felt availability and approachability of staff. Patients appreciated the efforts that staff made to remind them of their availability to discuss care concerns between home visits. During fieldwork observations patients were often reassured by staff that "we are only up the road" or said "we come past here nearly every day" or "we can always just pop in". Observations suggest that, particularly given the number of times that patients or carers were reminded of staffs' availability to them, very few patients took advantage of this unless they were especially unwell or anxious.

For patients and relatives receiving complex care at home, the availability of staff was sometimes tested. In these situations the responsiveness of a nurse to a patient's call for assistance (as well as the felt manner in which s/he responds) become important and enduring determinants of patients' experience of security. For example, one patients' wife recalled an event (of nine months previously) when "we called the ambulance but we also gave them a ring and the staff nurse shot right in here.. and she was so good because we felt so bad... they had said if you need anything then give us a shout.. well we know that now... it really makes a difference to know that" (010). It is notable that this sense of 'real' staff availability, whilst known to patients from the behaviours of one nurse, was assumed by patients to reflect a more general quality of this locality service.

This feeling of staff availability was enhanced for some patients by the reception that they received if they telephoned the community nursing team bases.

At the start on one morning shift, that the Band 7 team leader expected would be especially busy and demand her full attention to 'cover everything', this nurse received a telephone call from an elderly and confused man (and a former patient) who had mistaken her office telephone number with the GP reception number. She recognised the man's voice, immediately identified herself and asked after him before looking up the GP reception number in her diary and, slowly and calmly, reading this out for the man and then rechecking it with him. In the next twenty minutes, and as the office area became much more busy and demanding, the same

elderly man called her three more times with the same question. Each time she identified herself, asked after him and slowly read out and rechecked the same telephone number. Her own staff team listened on as she ensured that this man did not become lost within the high paced and task-driven concerns of the morning 'handover'.

The Downs and Ups of Care for Patients

As indicated in several of the examples above, patients did not consider this service to be flawless and were sometimes critical of the care that they received. Two notable aspects of this service were:

- Some nursing staff were much more popular than others with patients. Favourite staff were those who "make a connection" (012c); "aren't bossy" (012c); "don't rush me about" ((010), are not those who "don't have time for anything... have no time to talk.. and just do the job and go off" (012d) and "aren't super-efficient" (011). It was interesting then, that several regular patients were able to reflect on the wellbeing of staff and often commented on how different staff looked and sometimes behaved after annual leave.
- Some patients were often unhappy at regularly receiving care from different staff. They explained that this was because they felt less confident that clinical changes would be properly assessed (034) or worried that staff would know what to do or how to do it properly (012d;033;011). It is notable that, while many patients talked often about their positive experiences of (relational) care, they justified their concerns about the felt loss or inconsistency of (relational) care in terms of functional care requirements. One way that patients were able to insist on the value of relational care was to explain that "staff who know me better know how to do the dressing/[other clinical procedure] in the way that suits me [my clinical situation]' (012e; 034; 012d).

Nevertheless, all patients interviewed (n=14) and all patients involved in field observations (n=23) felt that their care was very good or excellent and were very positive about the quality of the service and the individual staff who delivered care. This suggests that, while patients were sometimes critical of some individual staff or particular aspects of the service, their overall experience of care was shaped by a general feeling of being 'known' and thereby connected into a staff team or the service. As one patient explained "we all have to do a bit of give and take together don't we?" (035).

9.5.5 Staff wellbeing

In this microsystem staff satisfaction was self rated highest and emotional exhaustion was self rated as lowest of all the eight microsystems. In addition, felt work dedication by staff was rated as high for a community microsystem. While this microsystem study supports the JD-R model and COR theory (particularly with respect to the value of local/workforce climate

for patient care and felt co-worker and supervisory support) the study also suggests that something more than a demand/resources model is important for understanding front-line patient care work. In all, however, the small size of this service locality staff group means that the staff (n=30) survey findings should be treated with caution. Staff interviews as well as observational fieldwork indicates that discretionary, and notably helping behaviours are unpinned by an ethic of care.

"Patients are never really the problem..." (601)

All staff interviewed noted that they enjoyed their work because delivering good patient care, and having good relationships with patients was satisfying work in itself. They also felt that palliative care work was their most challenging and rewarding aspect of their job because "it's where you really make a difference" (620; 601; 624).

The outstanding aspect of everyday work experience across this service locality was the circulation of a common ethic of care "that patients always come first". This ethic was frequently reiterated in formal meetings; morning and afternoon 'handovers' and in informal staff discussions and conversations (between themselves and with students and the researcher). Added to this was an often repeated view of trust in patients' expressed needs and intentions. Many staff often reminded the researcher, and one another, that "our patients are lovely [or lovely really]" (601;603;605;607;609;602;626;625;634;623) and that "people do funny things when they are worried" (601;603;602;626;634)'. Staff often enacted this ethic of care in their dealings with patients (see examples above) and senior staff, particularly Band 6s and 7s, were keen to instil this vision of care when working with junior colleagues and talking with their teams.

Following this view all staff had a clear and uncompromising view of the reason for their work: to provide for the immediate and, more occasionally, longer term needs of patients. According to this view, staff eschewed or devalued organisationally defined work that did not appear to be directed towards this purpose. In line with these staff interview and observational findings, staff survey ratings for discretionary (helping) behaviours was higher than were ratings for continuous improvement activities for patients.

Sources of Stress

Staff reported stress and irritation caused by work demands that diverted attention away from immediate patient care activities. These focused on:

- The introduction of the EPR system. While this system frustrated many staff in community services for different reasons (notably concerns with the organisation of patient and family information and issues of confidentiality and consistency between different systems) in this service locality (and in the service more generally) several older qualified staff felt undermined by the information technology skills demanded of them. Staff found the work time consuming and

stressful (they worried that they were not remembering or accurately recording patient care information). In one area of the locality service the EPR was out of date by 17 days as individual staff opted to focus on patient visits rather than on updating records.

- The demands of mandatory training. The tone of email correspondence through the organisation, the complicated system of booking training and the felt 'time wasting' content of this training was frequently noted by staff. In many respects staff felt that this reflected the approach and content of the organisation more generally.
- Intra-organisational working, and particularly working with GPs and practice staff, was a very different experience for different community nursing teams, varying from "feeling really valued and supported" (632; 641) to "a major stressor.. just totally undermining" (602; 620). Sources of stress in this work often centred on the failure of GPs to communicate the potential safety risks to staff when requesting home visits to some patients.

The stress and disagreements generated by poor intra-organisational working was often mediated by the locality manager "I often have to call up and remind them [GPs] that they can't walk around all over us" (640). Such interventions enhanced staffs' felt loyalty to each other and their locality manager (even if these were no signs that inter-organisational working was improved by this means).

The felt stress and resentment generated by new forms of working were felt by most staff to be caused by a detached and irrational organisation (even through these interventions were actually driven by extra-organisational innovation agendas) and further distanced service locality staff from the service and the organisation. The negative feelings of staff towards the service and the organisation were rarely articulated in complaints about staff shortages (in part because the service had gone to efforts to sustain staffing levels over several years) but in complains about managements' waste of resources that could have be spent on enhancing patient care.

Co-working and Occupational Communities

One key feature of staff wellbeing in this service locality was good co-working relationships between immediate colleagues (including trained and qualified and more and less senior colleagues). Staff described the importance of colleagues "to remind you [that] you are valued and cared for" (624); "to make you feel that you want to be at work" (625); "to keep you going" (601); "to back you up" (601) and "to be your safety net" (634). Colleagues' immediate expressions of care were valued to "stop you feeling isolated at work" (609) and "don't make you feel guilty if you have to go sick or take time back" (623, 637, 639, 641 in focus group). Staff recalled that they felt more isolated during evening or night shifts when they had much less co-worker support. One interviewee explained how, particularly when dealing with end-of-life care needs at night, she always "took work

home” and “went in [to homes] cheerful and came away exhausted” (609) because she could not share these times with her immediate colleagues.

Staff sometimes also indicated that keeping good relationships with immediate colleagues was sometimes also a difficult and even stressful dimension of working lives (147). Staff worked to “smooth things out” (636) or “read a mood” (625). All staff put care and effort into organising shared occasions (including shared lunch arrangements; ‘team only’ seasonal traditions; special birthday events or occasional gifts); some younger staff members (including the locality manager) were connected on social networking sites and other staff shared out of work activities. More generally, however, good working relationships in these service localities were regularly affirmed in a routine set of everyday work activities that included ‘ringing around’ (to offer co-workers help with covering late morning patient visits); enquiring after each others’ patients, particularly if they were especially sick or dying or a nursing visit was expected to be especially difficult; and, whenever possible, ‘listening into’ others teams’ handovers (in case they might need help with any of these patients at a later date).

Particularly in this service locality, where staff shared a felt distance from the values and activities of the wider organisation, ongoing team and co-working activities fostered a sense of occupational community between staff (331-333). This occupational community served nursing staff, and, indirectly their patients, in several different ways. First, it was a basis for practical learning, where functional and relational care was often interwoven in the ongoing discussion of patient care during office times and handovers. It is notable that senior staff in the service were resistant to the introduction of formal clinical supervision arrangements because ‘we do that already everyday’ (636). Second, the occupational community provided the social foundations for the ongoing sharing of work difficulties and dilemmas and, as indicated above, were the crucial focus for keeping a common and vibrant ethic of patient care. During ‘tea time’ discussions about patients and the challenges of patient care staff often reminded one another of this care ethic. Third, the occupational community furnished the context within which individual staff learned some details of individual patients who they were not currently or regularly caring for. It was often during the close of ‘handovers’ or during tea-breaks and lunch times that staff talked, sympathised, worried and giggled about patients’ changing circumstances or passing details of their lives or interests. These little details often became important to different staff when they first visited these patients. In this way, new staff could ‘break the ice’ and offer patients a sense of ‘being known’ and of receiving ongoing personal care.

9.6 Overview of qualitative fieldwork – Phase II

Here we provide a brief overview of the findings from our qualitative research in four of the eight microsystems, using the case studies described

above and those in Appendix 24 and in the additional Annexe available as a separate appendix alongside this report. We start with summarising the findings from the four community microsystems before addressing the four acute microsystems and then finally draw conclusions from across both sectors.

In three of the four community microsystems particular deficiencies in service design or specification, some highlighted by the impact of the Transforming Community Services agenda, had negative direct or indirect effects on both staff wellbeing and patient experience. In one microsystem (Adult Community Nursing Services [ACNS1], Ashcroft) over-ambitious service commissioning contracts combined with a history of poor co-working relationships and low perceived organisational support within most parts of the service led to generally low levels of job satisfaction and low positive affect in the workplace. Here, as in the Rapid Response Service in Larchmere (see Appendix 24 and Annexe available as a separate appendix alongside this report), poor service design led staff to perceived themselves as having little control over their jobs. However in the Rapid Response Service some professional staff also felt disillusioned and exhausted by both the increasing lack of clarity in the professional roles and the effects of this on patient safety. These staff also reported feeling a loss of professional credibility and guilt over their inability to redress perceived shortcomings in patient care and service delivery.

In the 'high performing' Community Matron Services in Ashcroft (see Appendix 24 and Annexe available as a separate appendix alongside this report), highly qualified professional staff reported high work autonomy and low job demands. However, as in the Rapid Response Service, a similar lack of clarity or consistency in job role, combined with a lack of felt support from the wider organisation, immediate supervisors and co-workers – left staff feeling dissatisfied at work. In the Rapid Response Service, long valued opportunities for team working and co-working between professional staff had been recently undermined by service restructuring that favoured particular professionals over others. In this service professionals' concerns with service reform also distanced them from close team-working with assistant care staff. In this service some senior professional staff, in particular, were successfully managing to minimise the impact of their low wellbeing on the experiences of their patients.

Our findings in the fourth and final community microsystem (the adult community nursing service [ACNS2] in Larchmere) appear to confirm - positively - how the interactions between organisational context and within-team relationships play a fundamental role in determining levels of staff wellbeing and patient experience. Here long-established relationships amongst staff - and between staff and patients - helped to maintain both a climate for patient-centred care and the delivery of services in a manner that addressed relational aspects of care in ways that helped shape overall patient experiences.

Findings from two of the acute microsystems (M for E and maternity) (see Appendix 24 and Annexe available as a separate appendix alongside this report), emphasised the crucial importance of local team climate for staff wellbeing and patient experience. In M for E the marked variation in ward leadership and multi-disciplinary team working between the different wards that comprised this microsystem, illustrated the effect of felt levels of co-worker and supervisor support. Consequently, and despite patients and carers consistently highlighting the fundamental importance of relational aspects of care to their overall experience, we observed a wide-range of staff behaviours towards patients on the different wards. In the maternity service co-worker support was again highlighted as being important and staff here reported the highest levels of positive affect in any of our microsystems as well as high levels of job satisfaction and job dedication. Unique amongst our eight microsystems, staff specifically highlighted the positive impact of supervisory and mentorship schemes; these also contributed to the strong professional identity amongst the midwives we encountered which appeared to accentuate a positive patient-centred care climate and resulting high levels of patient experience. Interestingly, however, staff here seemed much less likely to engage in the expected forms and levels of discretionary effort and continuous improvement (in conflict with some of the theories underpinning our model in Chapters 2 and 8). The explanation seems to lie - not in the absence of willingness - but in the lack of capacity (time, skills etc) to do so.

Our fieldwork in the haematology service resulted in the most - initially - counter-intuitive findings from any of our microsystems. Here we found consistently excellent reported levels of patient experience despite the highest level of negative affect amongst any of our eight staff groups and very high levels of emotional exhaustion. The inevitable emotional labour demands of working in such a service did appear to dampen individual motivation and capacity to engage in discretionary behaviours but a very strong local climate for patient-centred care substituted to some extent for the absence of high levels of staff wellbeing. Again, local climate appeared a key variable in providing excellent patient experiences albeit at the cost in this particular microsystem of individual wellbeing for some staff (as different staff members were able to manage their personal and professional boundaries with their chronically and seriously ill patients with varying levels of success).

Our final acute microsystem - the EAU - provided a clear example of how high job demands have a marked effect on staff wellbeing (in this case manifesting itself in terms of high levels of exhaustion and low levels of job satisfaction). This microsystem also provided the clearest example of how the wider societal context can also shape levels of staff wellbeing and patient experience; specifically, heightened consumer expectations. It is also important to highlight the fundamental difference between the nature of staff-patient interactions in a setting such as the EAU and - for example - the haematology service we studied. In EAU, short-term encounters

between staff and patients naturally lend themselves to an emphasis on the functional rather than relational aspects of patient care; this seemingly led to the relatively poor patient ratings of their experiences in this microsystem.

In summary, our qualitative fieldwork in Phase II across the eight microsystems suggests three key findings:

- the dynamics and interactions of a constellation of forces shaping staff wellbeing and patient experience at different levels of the healthcare system (wider societal context, organisation, team and individual) manifest themselves in different ways depending upon the particular features of different service settings
- (inevitably) there is a wide range of variation at the level of individual staff/patient interactions at different points in time and in different service settings, but that nonetheless,
- local team climate is a particularly important and a consistent variable.

9.7 Overall findings – Phase II

Our overall results in Phase II suggest that there is a relationship between employee wellbeing and various dimensions of patient care performance/experience, and that it is potentially quite complex.

Although our staff survey panel data suggested wellbeing does not have a very strong or clear direct effect on performance, it does show that wellbeing is importantly affected by employee experiences at work, as well as by individual skills and work orientations. Our descriptive statistics from our patient experience survey and staff survey indicate seven staff variables correlate strongly with patient experience including local/work-group climate, co-worker support, job satisfaction, organisational climate, perceived organisational support, emotional exhaustion and supervisor support. Our in-depth field work across the eight microsystems has facilitated greater insights into these variables and also highlighted the adverse impact of high quantitative job demands on staff wellbeing; and associations with significantly higher levels of emotional exhaustion, as well as with reduced job satisfaction, impacting on patient care (for example EAU and ACNS1). Our data suggest emotional exhaustion dampens the effect of job satisfaction and relative positive affect on performance, so that the positive effects of satisfaction and positive affect on performance tend to be nullified by high levels of exhaustion.

However, our data also suggest a win-win situation whereby high levels of patient care performance need not necessarily be achieved at the expense of employee wellbeing, and our results suggest that patient wellbeing is positively linked to staff wellbeing and that seeking systematically to enhance employee wellbeing is, therefore, not only important in its own right, but is also important for the patient experience.

Our data also suggest high levels of job control, as well as key personal resources, such as high levels of job skills, can help significantly to cushion the negative effects of high job demands on wellbeing by dampening the adverse effects of high demands on exhaustion, although when quantitative job demands are very high, high job and personal resources have a more limited positive effect on job satisfaction and positive affect. The buffering offered by high resources however, is important and our data suggest that critical in such support are supervisors, but also support from co-workers- the importance of 'communities of practice' and 'family at work' which we have highlighted in M for E and ACNS2. Our findings also show that the effect of wellbeing on performance depends, at least in part, on the climate for patient care. In particular, our results indicate that a strong climate for patient care at local and organisational level can help to reinforce some of the positive effects of wellbeing on performance. Critically such a climate can also act as a substitute for wellbeing in the sense of making up for the absence of high levels of wellbeing in terms of performance.

10 Discussion

In this three-year, mixed methods study we sought to explore the links between (a) patients' experiences of health care, and (b) staff motivation, affect and wellbeing. To better understand this complex set of relationships we pursued the study objectives outlined in Chapter 3 which were operationalised through our models of patient experience and staff wellbeing outlined in Chapter 2.

In the sections below we discuss our Phase I and II findings as they relate to each of these aims. Section 10.1 explores how patients describe factors shaping their own experiences that they perceive to be connected to staff wellbeing (aim 1) and the staff attitudes and behaviours they identify as doing most to improve their experiences (aim 2). This section ends with reflections on how patients, carers and staff can 'evaluate' the patient experience in different ways.

Section 10.2 introduces a multi-level framework to inform a discussion of how (a) the wider societal and NHS context, (b) the different organisational contexts in our four case study sites, (c) the characteristics of the eight clinical microsystems within those contexts, and (d) individual staff members and patients, separately and in combination with each other, combine to affect staff wellbeing and patient experience (aims 3, 4 and 5).

Section 10.3 discusses the strengths and limitations of our study and the implications of our findings. Finally, sections 10.4-10.6 discuss the implications, firstly, for practice- for enhancing the experience of patients and the wellbeing of the healthcare workforce, secondly implications for further research in this area and finally implications for policy (aim 6).

10.1 Patient experience

10.1.1 Patient perceptions of how staff wellbeing shapes their experiences

Patients, carers and relatives were able to speak of their experiences, and to reflect on aspects of staff wellbeing that may have impacted upon these. From these data we have determined those factors described by patients as shaping their experiences that may connect with, and be influenced by, staff wellbeing (aim 1). In our focus groups in Phase I patients spoke of poor or unsafe patient care because staff were tired, stressed and disillusioned and felt this was due to staff shortages and what patients perceived as poor organisational/management support. They identified poor collaborative working and poor ward leadership as leading to disorganised care and inequitable work burden between staff; and associated poor ward

and unit (built and social) environments with patients and staff feeling uncomfortable and tired.

Across our eight microsystems many of these same influences were identified. Many patients felt and observed the understaffing of their service, which meant delayed, untimely and unresponsive care. In low performing microsystems patients spoke of staff being either too busy (which they could excuse) or disinterested (which they could not) and how this manifested itself in unfriendly or poor relational care. Patients in high performing community microsystems identified team cohesion and stability as factors that enabled higher levels of relational care over time. Patients' felt that staff availability lead to improved emotional (making them feel reassured and valued) and clinical care. Patients' could discern which staff enjoyed their work and were proud of their service; linking this to staff who wanted to do 'a better job' for patients and 'go the extra mile'. Patients felt that these staff spent extra time getting to know them and improving their care experience. Patients felt that a more patient-focused approach helped staff to gain greater reward from their work.

10.1.2 Staff attitudes and behaviours that impact on patients' experiences of care

Patients had little difficulty describing those staff attitudes and behaviours that maximised or diminished their experiences of care (aim 2). Patients wanted timely care, and for staff to be responsive to them as individuals. Community patients wanted staff to be reliable and to visit as arranged, or let them know if they were going to be late. Patients also wanted to trust staff and feel reassured by them and to receive 'top notch' care. Not speaking negatively about their work or of other patients lessened patient anxiety and increased patient confidence. Expressing their enjoyment of work assured patients of their commitment. The mood of staff was critical for patients who noted staff as cheerful, friendly, moody, irritable, grumpy or rough. Patients spoke often of their joy in staff who were kind and friendly, who often had a smile and were willing to share a joke and to 'be personable'. Not only did this lift their spirits at a difficult time, it also built relationships and was a way for staff to demonstrate to patients they were making an effort and could 'be bothered'. However, these behaviours and attitudes also had to be genuine and patients noted the difference discussed in the emotional labour literature (117) between small talk that was not felt or meant and genuine interest in them as people. It is these relational aspects of care that demonstrated to patients that staff are interested in them, that care is individualised and responsive to their needs and preferences. Many of the staff attitudes and behaviours that maximised patients' experiences of care related to 'getting to know' each other and build relationships.

Many patients, particularly those in the community, wanted the same staff caring for them, who they knew and who could be trusted. Staff needed to be reliable and deliver on their promises (in terms of their availability or

following through on sending information for example). Another important attribute noted by patients was for staff to have a non-judgmental attitude. Accommodating some degree of incivility from an anxious, confused or unwell patient could still help build the trust of patients' and their family over time. In acute settings this can be particularly important, as staff are observed and judged not only by the care given to individual patients but by the care they are observed giving to other patients.

10.1.3 Patients' and their relatives' evaluations of care and judging patient experience

Friends and relatives also evaluate patient care and these evaluations can often be a more accurate representation of experience (334). Patients' evaluation of care includes what they saw and heard of the experiences of other patients; thus staff were 'on stage' all the time.

There was considerable variation in ratings of experience across microsystems that correlated closely with the study sampling (i.e. high and low performing services) which remained consistent across Phases I and II. Also noteworthy is the distinction between functional or transactional and relational aspects of care (98). Transactional' aspects of care (in which the individual is cared 'for'), meet the preferences of the patient as far as timing and location of appointments are concerned. 'Relational' models of care (where the individual is cared 'about'), is where care forms part of an ongoing relationship with the patient. Care received by patients in this study appeared to be largely functional apart from haematology, maternity, and community matron service and ACNS2 (community) which interestingly are the 'high' performing microsystems in each of the four organisations studied. However, all microsystems performed less well on the level of connection ('staff get to know patients as people') than other aspects captured by the Patient Evaluation of Emotional Care during Hospitalisation (PEECH) tool (330). This suggests that everywhere, but particularly in the low performing systems, staff fail to create meaningful relationships with patients – not connecting with the person in the patient, (something highlighted in a recent Care Quality Commission report) (335). Our case study data suggest these connections do not necessarily need to take more time, but to be meaningful they need to be genuinely felt/meant by both staff and patients. However our data also suggest that in a fast paced environment this may be more challenging for staff.

Whilst our findings suggest that staff wellbeing is important in determining patient experience, it is a complex relationship not least because the nature of a particular service naturally shapes important aspects of both staff and patient experiences. In our acute settings for example, high volume settings with a high turnover of patients who experience a short 'dwell time', like Emergency Admission Unit (EAU), make building relationships more difficult. Staff simply do not have time to get to know patients and patients have no reason to 'invest' in the staff. EAU had very high levels of staff stress, emotional exhaustion and low job satisfaction and one of the lowest patient

experience ratings. On the other hand, in the haematology service features of this patient group and their health conditions meant patients developed a long term relationship with the service and therefore an investment in staff on the wards as they returned frequently for treatment and built strong relationships both with staff and other patients. Patients here worked hard to shape relationships, demonstrating empathy towards nurses and feeling concerned for the busy, time-pushed, emotionally exhausted nurses. Gull (2011) (336) - examining compassionate nursing care with cancer patients - notes patients feel the need to "to give something back" emotionally or in token gifts to "replenish" nurses and describe the emotional connection as "circular" and a "two-way street"; making patients active participants in the nursing care relationship helping the nurse to help them (337). Staff in this setting appeared motivated to invest in these relationships, although they were keen not to become too 'involved' with patients. Yet, whilst staff stress and GHQ12 results were high in haematology, so too was job satisfaction. This microsystem presents one of the most complex pictures in terms of links between staff wellbeing and patient experience and will be discussed further below.

Thus because of the nature of the service settings, the illness trajectory and indeed individual patient factors, it appears that certain patients are much more likely to receive better relational care than others. Across a number of microsystems we learnt from staff, patients, carers - and our own observations - of variations in care for individual patients. Some patients were more 'popular' than others and staff were aware they had favourites and keen to manage such relationships so it did not become too obvious and ensure other patients did not feel neglected. Patients too, particularly in the community and in elderly care wards were well aware of the need to manage relationships with staff; to make themselves amenable to staff in order to secure improved care by staff's discretionary effort to gain better care. Our findings suggest that for patients the emotional labour involved in being cared for is greater in poor care climates where the quality of care is unpredictable and patient experience variable. Patients often seek to 'manage' relationships with a plethora of staff as well as their own responses, so as not to be seen as a nuisance or a 'problem' patient (337).

We encountered relatives and carers across all our settings and spoke with many of them, particularly in the community and care of the elderly wards. We noted a tendency in some settings for staff to see relatives and carers as a 'problem', a nuisance or 'extra work' rather than as a helpful and supportive ally in helping restore patients' health or live well with a condition. This was particularly evident in busy fast paced environments/ poor care climates such as EAU; M for E and ACNS1. Relatives opinions varied, with some more supportive and understanding of the pressures staff were under, and others felt let down by staff, or services. Some were critical of the care they saw others receiving, even if not of their own relative's care. In acute settings relatives and carers have time and opportunity to observe the work of staff with patients and make their

assessments accordingly. Many were grateful to staff, and admired their work and the NHS in general, and others drew on experiences in other settings to make comparisons, some favourable and others less so.

10.1.4 Staff evaluations of patient care

Staff did not always evaluate care in the same way as patients and relatives and there was much less variation between staff self-reported patient care performance across the microsystems than between patient report of experience (see Figure 31 page 165 'Performance as rated by patients and staff'). The greatest disparity between self-reported staff performance and performance rated by patients was found in the first adult community nursing service (ACNS1 in Ashcroft organisation) and the medicine for the elderly ward in Elmwick Trust. In these two microsystems - where care was rated poorly by patients - staff felt that the care they gave was better than it actually was, or certainly better than patients thought it was. Fieldwork observation and patient interviews also confirmed this, suggesting staff are either not receiving timely feedback from patients in their care or are not engaging in, or reflecting upon, this feedback to facilitate improvements. However, in these two specific cases there seem to be other interesting factors at work. In the medicine for the elderly ward at Elmwick staff had received an organisational development intervention because they were receiving so many patient and relative complaints, so they had known care was not perceived well by patients. Perhaps they believed it had improved, and in the light of our findings were reassured because older patients are less inclined to complain (for fear of care worsening) which may give a false sense to staff that care is better than it really is. For different reasons, staff in ACNS1 had also received little accurate feedback from their largely elderly client population. In a bid to reduce attrition managers had been telling staff what a great job they were doing, which it appeared staff had internalised. Neither scenario was likely to encourage staff to reflect on their practice and improve experiences for patients.

10.2 Multi-level framework

Reflecting on staff wellbeing and links to patient experience at macro, meso and micro levels:

We used a multi-level framework to determine how a wide range of factors at the macro-, meso- and microsystem levels, including the individual level affected and shaped staff wellbeing and patient experience. Below we outline each of these levels in turn before reflecting upon how dynamics and interactions between the different levels (311, 312, 328) are important determinants of staff wellbeing and patient experience.

10.2.1 Macro-system: the impact of the broader societal and NHS context

In terms of the wider context in which our fieldwork was situated we identified a number of societal trends that impact upon both patient experience and staff wellbeing. These trends include heightened patient expectations of both what modern medicine and nursing care can deliver and heightened expectations of customer service (157, 159), which we observed for example in our Emergency Admissions Unit (EAU) and to some extent in maternity services. In these settings a customer care model appears to influence health care and reframes patient as customer (159). Some authors have argued a consumerist approach undermines nurses' care orientation, and ultimately undermines their compassion (338, 339). In EAU and Maternity relatively brief encounters with staff coupled with high expectations of customer service in a consumer led society resulted in very high demands on staff and potentially unmet (high) patient expectations. Furthermore, in an increasingly litigious society, the need to keep and maintain good records has become paramount, leading staff and patients alike to feel frustration at what feels like 'unproductive' paperwork and record keeping, that takes staff away from direct patient care. The transforming community services agenda impacted upon our community microsystems through the realignment of services which created uncertainty for staff in terms of employment and their pension arrangements, and affected staff wellbeing through more recent introduction of performance management in these services.

Our data also reveal the impact of local demographics upon patients' experience and the work of staff. Societal trends such as alcohol and substance misuse problems can culminate in greater levels of more serious violence and aggression towards staff (EAU). In the same Trust, in another setting, an increase in birth rate in a new immigrant population has caused greater demand and communication difficulties for both staff and patients. These issues layer complexity and challenge onto an already overstretched service. In another Trust (Larchmere) and microsystem (ACNS2) where there was little movement in or out of the area, we observed a very stable, supportive and tight knit staff team, where individuals knew each other and had worked together over a long time. This tacit knowledge also extends to their patient groups allowing for a richer and more individualised patient experience, and one that was rated highly by patients themselves.

In many of our microsystems the patient population was comprised mainly of older people (e.g. MforE; ACNS1; ACNS2). Increasing numbers of older frail people coupled with an ageist society in the UK has placed increased pressure on the UK healthcare system (340). Working with older people is seen as having low value and esteem leading to problems of recruitment, retention and motivation of healthcare staff. Caring for older people is perceived as being the 'least glamorous' and is a stigmatised area of nursing and medical work. If students enter nurse education with a desire

to work with older people once qualified, by the end of their course this has significantly diminished (341). These workforce issues were apparent in the Medicine for the Elderly service at Elmwick. In community settings where many older people are cared for, we noted difficulties recruiting staff into (perceived low prestige) generic community nursing services and a reliance on ageing staff and bank and agency staff, particularly in ACNS1 in Ashcroft.

We encountered significant difficulty in collecting data from older people using NHS services; indicating that their 'voice' is seldom heard. When we did gather patient experience data directly from older people their expectations of care was relatively low, and they did not like to complain, feeling particularly vulnerable and fearing their care might worsen if they did so.

At a national healthcare system level an ever increasing patient demand (greater numbers of patients), with higher patient acuity, increased throughput and greater patient complexity creates quantitatively and qualitatively high demands for staff in acute and community services (157, 159, 339, 342) that has an adverse effect on staff wellbeing, resulting in reduced patient care performance.

10.2.2 Meso-system: organisational contexts in our four case study sites

At the organisational level we offer a number of reflections across our four sites. Firstly, organisation-wide initiatives will only bear fruit if they are also embedded at the microsystem level. For example, in Oakfield whilst the revised staff induction programme was a potentially important intervention to improve patient experience and encourage staff to develop the 'right' attitudes and behaviours, it needed to be supported and strengthened at the service level to be effective. The leadership development programme in this Trust may be sufficient to support this, but not necessarily. Similarly, an organisation-wide staff work and wellbeing survey will only be effective if acted upon and interventions are developed to support staff in their work. Indeed surveying staff to establish their wellbeing is likely to raise expectations and do more harm than good if results of the survey are not acted upon. A 'management of stress' working group, such as that seen in Oakfield Trust, needs to examine the wider structural causes of stress, such as high demand and low control and inadequate staffing, rather than treating burnout and stress as individual pathologies (343). Oakfield Trust was also an organisation in crisis at the time of our fieldwork (the Chief Executive and Chairman both left under stressful circumstances) and staff ratings of organisational climate and organisational support were especially low in the EAU microsystem in this Trust. Interestingly the impact of this poor organisational climate seemed less relevant in the maternity service in the same organisation, possibly because of the positive effect of the strong professional identity amongst the midwives and sense of teamworking. By contrast in the Community Matron Service (CMS) in Ashcroft Trust strong

professional identity, advanced clinical role and responsibilities did not insulate staff from the felt effects of unsupportive management and poor recognition by the organisation. Several staff described times when they felt particularly unsupported by their service manager (when requests for compassionate leave and unpaid study leave were refused without discussion and when one matron faced a formal complaint by one patient's relative with very limited advice and support from their manager).

Most staff in both microsystems in Ashcroft community organisation were highly cynical of any interventions undertaken by the organisation to improve staff wellbeing. Front-line staff felt that the poor interpersonal behaviours of organisational and service managers towards them, as well as ever increasing and unreasonable workloads, negated any directed organisational attempts to improve staff wellbeing. Many senior staff also dismissed all organisational interventions in the same negative terms as ineffective and undertaken only to meet procedural requirements. Thus one Nurse Consultant remarked "if it meant improving scores they would train us to shut the door". Many staff in Ashcroft also did not feel that the patient experience agenda would have a positive impact on patient care or staff work practices. These staff felt that the expansion of this agenda into community services would simply add to their administrative workloads. Our findings within adult community health services (ACNS1) in the same Trust also indicate the negative impact of uncertain organisational and service futures on staff wellbeing and, in the long term, on the retention of highly trained and dedicated professional staff.

In Larchmere Trust staff - in contrast to those at Ashcroft - noted their appreciation of organisational managers' efforts to engage them in ongoing innovation reforms. However, staff generally felt that these efforts expressed managers' recognition of them but did not necessarily improve their wellbeing at work. Staff agreed that 'high level' interventions had a minor impact on their working lives and that good team working and close peer relations were the keys to their wellbeing. Staff in the poorer performing service in Larchmere felt that trust and collaboration between colleagues in the immediate workplace enabled them to withstand the stresses and anxieties caused within, and beyond, the organisation. Thus where we saw a stable and cohesive staff team and tangible organisational resourcing in ACNS2 we also witnessed higher levels of staff wellbeing. Conversely where there were over-ambitious service commissioning contracts - leading to high job demands and low control - there was poor staff wellbeing and poor patient experience of care (ACNS1).

Within the two acute Trusts, the initiatives witnessed in Elmwick were the most likely to be effective, although sustained and intensive intervention was required to see them through. Trust senior management clearly understood the importance of staff wellbeing and its impact on patient experience (more coherently than the other three case study sites). Although, as found at Oakfield, follow through from the staff wellbeing

survey with tangible initiatives to improve staff engagement was important for organisational change, yet was not always felt by staff. Indeed staff commented on the 'corporate' feel in the Trust which some saw as alienating. What was undeniably impressive at Elmwick, however, was the large resource put into, not only collecting patient experience feedback, but acting upon it and feeding it back at a local level. A high number of patient complaints in the medicine for the elderly service led to a targeted organisational development intervention which was a real attempt to engage staff in the issues facing them that were leading to poor patient experience. Many of the issues highlighted in the report of this work were echoed in our own case study findings, suggesting that there was still more work to be done with staff on some of the wards to build teamwork, support for each other, reduce bullying and strengthen local ward leadership to achieve a sustained cultural change. Clearly, turning a relatively low-performing service around and investing in staff, cannot be achieved by a one-off event and once expectations are raised by such interventions these need to be delivered upon over a period of time to ensure staff do not become even further disengaged by the process. Sustained investment is particularly important in such a service where the disconnect between senior management and front-line staff was so clearly felt.

10.2.3 Microsystem: our eight clinical services, staff and patients

At the microsystem level, we noted a number of issues pertinent to our study concerning the links between staff wellbeing and patient experience which will now be the subject of further discussion.

Multivariate analysis suggests that the wellbeing of employees is affected by the quality of their experiences at work. Important amongst these work experiences are job demands and social support which we identified as being important predictors of wellbeing. Across microsystems high quantitative job demands adversely affected wellbeing, while high levels of social support contributed to better wellbeing. We also observe that when staff wellbeing is low, in particular job satisfaction, so too is patient experience.

Quantitative job demands were particularly high in the acute microsystems and ACNS1 (Ashcroft) and RRT (Larchmere). Supporting JD-R and conservation of resources (COR) theory and research (32, 33, 35). These high levels of job demand have a marked adverse effect on wellbeing and are associated with significantly higher levels of exhaustion, as well as with reduced job satisfaction. We noted high levels of emotional exhaustion in EAU and low job satisfaction and the same in ACNS1, both low performing microsystems for patient experience as well as staff wellbeing.

Our results also indicate that high levels of social support from supervisors, co-workers and the organisation has a positive effect on wellbeing in that it helps to reduce exhaustion, while at the same time enhancing satisfaction

and relative positive affect at work. This was evident in several of our microsystems, most notably, maternity; haematology and ACNS2. Here we witnessed the importance of local support, co-worker support and team cohesion; this recalls the notion of 'communities of practice' (Le May 2009) (344) or what some of our participants called 'family at work'. Also notable in these microsystems were the high levels of supervisor support and strong leadership at the local level, e.g. in community team and locality managers. Also notable was the reported high team functioning in those microsystems where staff felt supported and where patient experience was good or excellent. Such high resources and support can help individuals to cope more effectively with high levels of quantitative job demands, thereby buffering them from the worst adverse effects of intense job demands. In maternity for example, staff noted the value of mentoring and supervision and felt this was an important part of a supportive team climate; similarly staff in ACNS2 stressed the importance of local workgroup environments. In both these settings patient experience was good or excellent. Conversely in M for E and ACNS1 there was evidence of poor team working and cohesion and poor co-worker support/poor local climate for patient-centred care; this appeared to undermine the effect of any positive, wider levels of organisational support. In some of the M for E wards, tensions (and some allegations of bullying) between different grades of staff, and staff from different ethnic backgrounds; together with poor local leadership and management of staff were significant factors. The importance of the team, and the team leader role in supporting and nurturing staff, and building a strong climate for patient care was also notable because of the marked variation in the performance of staff on the four wards within this service. Similarly, in ACNS1, with its overall poor staff wellbeing and poor patient experience, marked variations were observed in the performance of staff teams in different localities within the service. Both ACNS1 and M for E had poor patient experience, emphasising the critical role of such local leadership at locality or ward level in setting expectations of values, behaviours and attitudes to support the delivery of patient-centred care. These observations add to our understanding of the importance of 'supervisor support' and 'leadership' at local ward level and thereby build on the model described in Chapter 2.

Although high job resources of various kinds (e.g. co-worker support) can positively contribute to key aspects of wellbeing, they are more likely to do so where job demands are less intense. Thus high job demands can significantly dampen, if not completely neutralise, this positive effect. For example in EAU where co-worker support appears neutralised by high job demands resulting in relatively low job satisfaction low positive affect and largely poor patient experience. In some community services the effects of the TCS agenda also dampened the effects of co-worker support and of job satisfaction. For example in the Rapid Response Team both co-worker support and inter-professional working was undermined by changing commissioning interests and agendas which were expected to advantage

some professional groups over others. In this service also, job satisfaction was felt to have declined significantly as professional staff felt that they had declining influence over service development. In contrast the effects of high job demands and stress in Haematology were attenuated by high levels of co-worker and supervisor support and high local work group climate leading to excellent patient experience; it is possible that these interact to buffer and reduce the impact of the other factors but, perhaps more important, are the strong relationships forged between staff and patients in an emotive and (atypically) long-standing health-care 'encounter'.

In this study our data suggest the microsystem team level was the most important for staff wellbeing and for associated variation in patient experience. It is at this level that staff form relationships with each other and with patients; work as a team; are supported or otherwise by inspiring leaders, role models and co workers. We would suggest it is these aspects of day-to-day work that renew staff and enable them to develop resilience which supports and enables the delivery of high quality care to patients.

10.2.4 Individual level

Our findings also suggest that the wellbeing of employees is importantly affected by not only the quality of experiences at work as discussed above, but also by key individual characteristics and orientations. These include high levels of work dedication, job skills and competence which contribute to a greater sense of wellbeing at work. Work dedication is consistently positively associated with higher levels of wellbeing, including lower exhaustion and higher job satisfaction and relative positive affect. Staff in EAU had very low work dedication, low job satisfaction and high exhaustion; whilst those in maternity reported high work dedication, high job satisfaction and relatively low exhaustion. Exhaustion (high job demands and low control) reduces motivation and capacity to engage in desirable in-role and discretionary behaviours (as seen in EAU). In particular, high job skills and competence help to reduce or minimise emotional exhaustion. Thus, and perhaps contrary to recent media reports questioning whether nurses need a degree, it is important for nurses to be well educated and for nurses and health care support workers to be given ongoing training to develop skills and competencies. At the same time, as illustrated in our examination of Ashcroft community organisation at the meso-level illustrates, effective staff training initiatives require the support of service managers and team leaders (to protect time for staff to train and opportunities for skills consolidation).

The effects of high job demands can be seen on individual behaviours. For example, high levels of emotional labour and job demands in haematology lead to emotional exhaustion as did high demand and low control in medicine for the elderly. Such job demands limit staff capacity to give discretionary effort (maternity; ACNS1; M for E) but in maternity the importance of a strong professional identity (midwifery) and a shared view

of purpose of their work (ACNS2) appeared to support staff and provide some buffer allowing staff to deliver high quality care.

In terms of high levels of emotional labour, our 'stand out' microsystem was haematology. Patients in this microsystem, had the best experience of care across our acute areas (92% rated their care as excellent/very good and 86% would definitely recommend), yet staff were the most stressed and had relatively low self reported affective patient orientation and relatively high job demands. Within these settings staff reported managing their emotions and their stress so that patients were not aware of what they were feeling - surface acting (117) -but staff also reported the challenges of managing their emotions with patients with a life threatening illness such as leukaemia and other life limiting blood disorders. Many patients were relatively young and staff identified with their situation and many felt genuine empathy, which may be one reason staff in this microsystem reported high job satisfaction, but also high levels of stress. As we identified in the literature in Chapter 2, surface acting is thought to lead to a sense of inauthenticity, increased stress, emotional exhaustion and lower job satisfaction (124, 132, 134).

Individual staff were observed to manage their personal and professional boundaries differently, with more experienced staff better at coping and managing such boundaries and the stress involved, echoing the findings in Bolton (159). This suggests newly qualified staff need more support and guidance in managing such boundaries if they are not to burn out quickly and leave the profession (40). In RRT there were also distinctions between registered professional staff and care assistants, with the latter drawing upon the specialist work experience and skills of other team members in order to better manage role stress. 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.

10.2.5 Summary

Our study has not only revealed large variation between quality of patient care within our eight microsystems, but also between individual staff. It appears that some staff can give high quality patient care under the same organisational climate while others can't. We suggest this has much to do with individual factors, such as level of skill, experience, tenure and temporality. For example, staff who have high levels of work dedication tend to express greater wellbeing and those with high levels of job skills and competence contribute to a greater sense of wellbeing at work. This has important implications for the selection and induction of new employees, as well as for their continuing and systematic training, development and up-skilling once they are in post. There is also an important temporal aspect that is important to note. For example, we noted in some microsystems

(e.g. CMS) that in the short term staff can undertake emotional labour but this is not sustainable over the longer term and staff 'move on' to other things.

At present, NHS patient and staff surveys do not give sufficient detail of local climate and thus at present do not provide enough local intelligence on which to base interventions. However many Trusts do undertake local level data collection which this study would support. Managers in our sites typically knew where the highs and lows in the service were and to some extent the issues driving them. We commend Elmwick for their further investigation into the high numbers of complaints in Medicine for the Elderly and their OD intervention with facilitated focus groups and in-depth interviews with staff to further understand the complexity of the problems. Such interventions however need good resourcing, commitment and follow-through to avoid further alienating an already disillusioned and demoralised staff.

Overall, we would draw attention to the interactions that occur between the levels outlined above (macro- societal level; meso- organisational level and micro – microsystem- team and individual levels). Interactions between the levels shape the relationship between staff wellbeing and patient experience, so for example although we have highlighted local/team climate as being very important it is also how this level interacts with other three levels that actually determines staff wellbeing and patient experience (e.g. ACNS2 shows the power of having BOTH organisational and team climate working together). We suggest therefore that it is important for researchers and indeed NHS organisations as well as individual organisations to study more than one level.

We also suggest that differing 'bundles' of key antecedents of wellbeing are critical for supporting staff to deliver high quality patient care and also to enhance staff wellbeing per se. These 'wellbeing bundles' that strongly correlate with good patient experience are likely to include:

- local/work-group climate
- co-worker support
- job satisfaction
- organisational climate
- perceived organisational support
- Low emotional exhaustion, and
- supervisor support.

As we have observed, social support from supervisors, co-workers and the organisation has a positive effect on wellbeing through reducing exhaustion, while also enhancing satisfaction and relative positive affect at work. Job resources, such as high levels of job control, as well as key personal resources, such as high levels of job skills competence and work dedication are also important in that they help by dampening the adverse effects of high demands on exhaustion.

10.3 Strengths and limitations of study

10.3.1 Strengths

The strengths of this study lie in its multi-method; multi organisational; multi-participant and multi-level design.

Multi-method: we gathered data in a number of ways – with a large patient survey (n=498) and staff survey (n=301) and in-depth case studies, using interviews and observation to deliver detailed findings from our eight microsystems. Triangulation of data from multiple sources improves our understanding of staff wellbeing and patient experience through analysis and comparison between the various data sets (345, 346).

Multi-organisational: we sampled four organisations, two acute and two community Trusts and within each we have focussed our attention on two microsystems. These were sampled to reflect extremes in terms of staff wellbeing and patient experience to help shed light on the mechanisms and influences upon staff wellbeing, patient experience and any links between the two within the same broader, organisational context.

Multi-participant: we have included a range of staff and professional groups: registered nurses; allied health professionals; health care support workers; student nurses; doctors- junior and consultant level and administrative staff. We included patient level data, from individual patients, and in some cases their relatives and carers, some of whom (e.g. older frail community patients) are seldom heard.

Multi-level: we included the views of front-line staff as individuals, as members of teams, organisational views (i.e. managers and senior executives) and an investigation of organisation-wide patient experience and staff wellbeing initiatives. We examined our findings in light of the wider societal trends and context and have interpreted our findings at each level.

10.3.2 Limitations

In our proposal, we critiqued previous work for being cross sectional, focused on uni-professional groups and for not linking individual staff and patient level data. Whilst we have attempted to address a number of these limitations, we have not been able to fully address all these issues. The scope and scale of our work across four organisations and in eight microsystems has limited our opportunities to engage in detailed longitudinal work. Our case study data were collected over a period of 3-4 months, but apart from this and the staff survey (two occasions), our data primarily provide a snapshot in time, a cross sectional picture of patient experience and staff issues. We had originally hoped to obtain a multi-occupational staff sample but ultimately it mainly comprised of registered nurses and support workers. In community settings the workforce was almost exclusively nursing staff. We had anticipated for more medical staff

involvement from our two acute sites, but despite considerable effort to recruit doctors, the numbers agreeing to participate was disappointingly low.

A strength of this study is that we have gained patient and staff level data from each microsystem – so we do know which patients were cared for by which staff. However direct staff and patient linkage through our surveys was not possible. We do have data from patient interviews that identify individual staff members and their attitudes and behaviours which maximise patients' wellbeing and experiences of care, which contributes important knowledge to this body of research.

Other limitations arise from challenges in the field that were difficult to overcome. Accessing patient and carer experiences in community settings and in Elmwick medicine for the elderly proved very difficult. Patients in these services were often very frail, elderly people who were not able to recall details of the services, the staff who cared for them or complete the questionnaires. Despite various approaches securing engagement of this patient population was challenging, and limited the amount of data that could be collected.

We also had difficulty gaining research access to Ashcroft. This was an ongoing process of protracted negotiation and renegotiation, as we encountered different managers and gatekeepers. There were also significant changes in management restructures and clinical service provisioning in preparation for the integration of Ashcroft into the neighbouring Healthcare NHS Trust. Having commenced negotiation for Phase II entry into the field in September 2009 we were granted access to this service in late June 2010.

Finally, response rates on the staff survey were disappointingly low in some microsystems, particularly at time 2 and we were unable to collect round two survey data from staff in one of the community sites (ACNS1). However, this problem aside, the overall response rate on the time 1 staff survey was, as we note in the methods chapter (Chapter 4), quite good, and in line with response rates on many employee surveys reported in the management or organisational behaviour literatures. The panel sample response rate also compares quite favourably to response rates commonly obtained in repeat surveys. Furthermore our response rates do not appear to have impacted noticeably on the quantitative analysis or the main conclusions from this part of the study.

10.3.3 Impact of patient and public involvement on the study

The added-value of service user involvement in this study can be clearly demonstrated in a number of areas. Involving service users in designing and planning of the research has made notable differences to the research design. These included the addition of patient focus groups to Phase I of the research (which informed the later design of the research approach in Phase II); changes to the format and wording of the patient experience

questionnaire (less use of jargon and simplifying the language and length of some questions); identification and recruitment approach to patient research participants (reviewing information provided and the initial approach to patients and consent process), the interpretation of research findings (drawing out key messages for patients, carers and relatives, and for patient organisations).

Important insights have been gained about the specific role of patients in engendering change- both through contributing their experiences (consultation), and direct involvement in the research (collaboration). With regard to the impact on the quality of the research data patient accounts of their experiences are vivid, and emphasise the importance of relational aspects of care. In our focus groups patients were able to discriminate between what they judged to be 'good' and 'bad' individual staff behaviours. These views were balanced by recognition of the influence of the workplace, management and physical environment.

We can only speculate about what the research findings might have looked like if patient perspectives had not been heard and used to inform the research. However it is likely that the relationship between patient experiences and staff motivation and wellbeing may have been seen as unidirectional and less attention may have been paid to the reciprocal effects of changes on each side of this relationship.

There are important messages for patients, carers and relatives from this research and for patient and carer organisations. We have suggested what these are in sections 10.7 and 10.8 of the report. We plan to work with patient and carer organisations to disseminate these key messages and to gain their feedback about the research findings.

10.4 Implications for practice: the management of front-line staff and improving patient experiences

10.4.1 Enhancing staff wellbeing

Our results suggest that individual employee wellbeing is best seen as an antecedent rather than as a consequence of patient care performance.

- It is therefore important to invest in and support individual staff wellbeing at work, not just for its own sake, but to enable the delivery of higher quality patient care.

Our study has drilled down into eight clinical microsystems and, although revealing large variation between them:

- Where staff well being is good, patient experience is good, and vice versa (with the exception of our haematology microsystem).

Furthermore, our initial sample identified by senior managers of high and low performing microsystems in Phase I has been validated by our in-depth fieldwork in Phase II. This suggests that:

- Within organisations senior managers are able to distinguish between service areas that need investment and support (in terms of improving patient experience), and those that are doing well.
- Key factors ('wellbeing bundles') explain the differences of staff wellbeing across the microsystems, which are:
 - local (team)/work-group climate
 - co-worker support
 - perceived organisational support
 - emotional exhaustion, and
 - supervisor support.

Our study has therefore highlighted the importance of the local work environment, the ward and local team on employee wellbeing and relationships at work.

These factors impact upon job satisfaction and - we also suggest - upon patient care performance. We therefore observe that organisations may need to:

- Target their limited internal resource to areas that are known to be problematic either in terms of low patient experience (complaints) and/or poor staff wellbeing (indicated by, for example, high sickness absence, reports of bullying or disciplinary issues).
- Disseminate the learning from those areas that have good patient experience and high staff wellbeing (and are known to be places where staff want to work) for example by linking specific wards through buddying of ward managers to help challenge and transfer learning from one to the other.
- Ensure that team leaders are aware that investing time and energy into team building is of critical importance for patient care delivery.

Our in-depth field work has also highlighted the adverse impact of high quantitative job demands on staff wellbeing; and associations with significantly higher levels of emotional exhaustion, as well as with reduced job satisfaction, and poor patient care (and particularly the relational aspects of that care). Furthermore:

- Any positive effects of satisfaction and positive affect on performance tend to be nullified by high levels of exhaustion.
- Various forms of active support at work are therefore critical not only from supervisors and co-workers, but also from the organisation as a whole.
- More decentralised forms of job design that give employees higher levels of discretion and control over their job.

Our results have clear implications, not only for the design of jobs in health organisations, but also for the quality and nature of organisational and local leadership and supervision. Thus, we observe it is important for NHS organisations to:

- **Systematically measure, monitor levels of quantitative job demands.** Pay attention to job demands associated with different

care environments and where possible limit these as a key way of minimising levels of exhaustion amongst employees.

- **Invest in unit level leadership and supervisor support** (i.e. ward sister level in acute and team leaders in community)- need managers who can promote good team working and supportive peer relations.
- **Build teams and teamwork** - invest more in how teams function and perform. Encourage co-worker support and a sense of 'family at work' by maximising key job resources that we found were linked to a variety of positive experiences at work, and which can therefore actively contribute to higher job satisfaction and positive affect, for example:
 - Ward managers and team leaders in nursing should consider:
 - **Active team building:** create positive space (e.g. ward teas) to get to know colleagues and places to talk about challenges or fissures in ward teams before they become embedded to build a greater sense of family at work – particularly in teams that are fractured in some way i.e. different staff grades; different professions and different cultural and ethnic backgrounds
 - **Facilitating greater staff empowerment** and ownership of their work – through for example more decentralised forms of job design that give employees higher levels of discretion and control over their job.
 - **Resilience building and renewal for staff-** create support and supervision for staff to reflect on the emotional and physical challenges of caring for people- for example regular opportunities to discuss 'difficult patients' and how these might be managed; clinical supervision as in our Midwifery case study and in Mental health (347). Schwartz Rounds¹¹ are one way to create space to talk about the emotional aspects of care work in the multi-disciplinary team.
 - **Developing a supportive local care climate** that is enabling for staff but which also sets clear expectations, goals and direction for patient care performance.
 - **Setting a positive emotional 'tone' of care delivery** for staff and patients and the need to treat staff as they wish staff to treat patients.

¹¹ Schwartz rounds have been brought to the UK by the King's Fund Point of Care programme from Boston Massachusetts where they originated. The rounds take place in 195 sites in the USA and currently 10 in the UK with expansion planned. The rounds (usually 1 hour each month) provide space for 'renewal' by practitioners and recognition, re-enforcement and support from colleagues and managers.

http://www.kingsfund.org.uk/current_projects/point_of_care/schwartz_center_rounds/index.html

- **Free clinical staff to lead and manage their own staff** i.e. ward managers and team leaders and this includes staff recruitment and support to performance manage staff around the following areas:
 - Ensure high levels of job skills and competence amongst front-line employees.
 - Recruit to organisations' core values to include high levels of work dedication (strong sense of involvement in work, enthusiasm, inspiration, pride, and challenge).
 - Examine attitudes and beliefs in staff and champion continuing and systematic training, development and up-skilling for existing staff and for new recruits once in post).

10.4.2 Enhancing patient experience

Our in-depth fieldwork in the eight microsystems has revealed much about what patients and carers want from their care, as well as patients' perceptions of how staff wellbeing shapes their care and which staff attitudes and behaviours impact upon patients' experiences of care.

- Our data suggest that interpersonal relationships with staff (being 'known') are critical to patient experience.
- **Patients want and value good relational care**, and it is relationships with staff that are often highlighted in patient complaints (CQC 2011). This means:
 - **genuine interest** in them as people; as opposed to small talk that is not felt or meant.
 - **continuity in staff** in order to enhance levels of trust and understanding about care needs;
 - **non-judgemental staff** who can understand the reasons behind moments of patient incivility (e.g. fear, anxiety, grief).
 - **competent staff** who express enjoyment in their work; and
 - **inclusion of relatives and carers** in the care giving process in whatever way is appropriate, to include being kept informed and involved.

Our data however suggest that across all our case studies - but particularly in acute care - the level of 'connection' with staff was poor, particularly in low performing areas. Thus:

Support for staff to deliver relational care: organisations need to enhance staff's ability to engage with patients on a meaningful personal level (see resilience and renewal above). Supporting staff to deliver such high quality care is long term work (and amounts to much more than offering staff a 'script' for patient encounters). Staff reported not being able to deliver the care they wished to thereby supporting much research in this area which suggests staff enter the caring profession to deliver high quality care but that the process of caring in an environment which does not support this dehumanises them, resulting in burnout and intention to quit. Lack of sufficient staff and skill mix tops the list of what stops staff delivering high quality care.

Senior managers and leaders could consider investment in staff work environments to ensure quality patient care. For example:

- **Optimise patient and relative experience feedback:** access to data for all staff via different approaches (not only patient surveys)– e.g. complaints, compliments, real-time feedback; ensure staff have sufficient opportunities to reflect on how good or poor care is in their area/teams; facilitate discussion re 'demanding' patients and educate staff to recognise the 'unpopular patient'. Support staff to develop and see through patient experience action plans.
- **Direct access to patient experience:** build in opportunities for staff to ask patients and their relatives what staff are doing well and what they could do better. This may reduce staff over-estimating the quality of care they are giving.
- **Leadership and support:** invest in unit level leadership and supervisor support to create well functioning teams and to understand the links between ward climate and staff wellbeing and patient experience (as outlined above in staff wellbeing). Ensure support is implemented and sustained at area/team level for patient experience improvement initiatives.
- **Adequate staffing:** use tools of acuity and dependency to argue for sufficient staff for the level of need of the patient population.

Our study has also identified wellbeing 'bundles' which would enable organisations to support their staff to deliver high quality care (see above).

As we discussed in chapter 2 (Section 2.3.2) of this report, Shaller (96) identified seven strategies for achieving excellence in patient-centred care at the organisational level:

1. **Leadership**, at the board level, sufficiently committed and engaged to unify and sustain the organisation in a common mission.
2. **A strategic vision clearly and constantly communicated** to every member of the organisation.
3. **Involvement of patients and families** at multiple levels, not only in the care process but as full participants in key committees throughout the organisation.
4. **Systematic measurement and feedback** to continuously monitor the impact of specific interventions and change strategies.
5. **Quality of the built environment** that provides a supportive and nurturing physical space and design for patients, families and employees alike.

6. **Supportive technology** that engages patients and families directly in the process of care by facilitating information access and communication with their caregivers.
7. **Care for the caregivers through a supportive work environment** that engages employees in all aspects of process design and treats them with the same dignity and respect that they are expected to show patients and families.

Our findings would support these seven but with the addition of another strategy:

8. **Strengthen team and a local climate** for patient care underpinned by strong *local* leadership, co-worker and supervisor support (see above for specific strategies).

10.5 Implications for future research

Our work offers direction for future research in this area:

- Further in-depth longitudinal work to examine links between staff wellbeing and patient experience in selected services where survey approaches are unlikely to yield sufficient insight (e.g. elderly care). In particular this work could focus on how staff renew and build resilience, retain empathy and warmth for patients and continue to champion quality patient care.
- A survey-based study which can link staff wellbeing and patient experience at the individual staff/patient level across a greater number of microsystems (e.g. across 40 wards in a Trust) to confirm or disconfirm our results in a large population.
- More specific studies at organisational and local levels to explore how different climates impact upon the delivery of high quality patient care, for example:
 - The role of local team climate in providing support to staff (what does a 'model' high quality care team look like and is it different in different settings?).
 - The role of middle managers and ward leaders in providing support to staff.
 - The value (impact on wellbeing) of mentorship/supervision for staff.
 - Evaluation of strategies to build resilience and support renewal in staff.
 - Support for newly qualified staff with managing emotional boundaries to reduce burnout and emotional exhaustion.
- Evaluating the impact of the 'bundles' we have identified across the different levels (macro; meso; micro and individual).
- Exploring and evaluating the concept of work dedication as a wellbeing 'buffer'.

10.6 Implications for policy

The Boorman Review (2) was heralded as a watershed in improving wellbeing at work for the NHS. Yet despite critique from Steve Boorman of Occupational Health (OH) departments, they remain the key mechanism for delivery of much of the staff wellbeing agenda. The image of OH remains very poor and as Boorman himself noted can be "part of a punitive process", questioning whether OH services meet the needs of organisations today. The "Healthy staff, better care for patients: realignment of occupational health services to the NHS in England" document (348) outlines the characteristics of a new-look OH service, including the need for it to contribute to improved organisational productivity. We suggest staff wellbeing, as conceptualised and described in our study, is about much more than physical wellbeing, healthy lifestyles and individual staff stress, important though these are.

If OH is to continue to be aligned with delivery of a broader staff wellbeing agenda, then there is a need to bring OH issues much closer to the work of Trust Boards, so that it becomes central to delivery of the clinical vision. OH departments need to be adequately resourced and linked to OD departments in Trusts so that issues such as high sickness absence are not tackled in a reactive and punitive way but are seen as a barometer of wellbeing issues that affect care delivery and care quality.

Reports of high sickness absence need to be examined in context of the local care environment to determine if there are individual (stress; injury etc); team (lack of support; bullying); organisational or wider contextual issues at play. These issues need to be highlighted at Board level and measures taken through OD to manage them; our study suggests such a strategic approach to improving staff wellbeing will have a positive impact upon patient care quality and experience. We suggest a broader framing of OH would be helpful and that staff wellbeing data can be sensitively used by OD departments to intervene and support staff to develop their practice and wellbeing to proactively support and manage relationships with other staff and patients.

We therefore support the idea of an agreed minimum dataset for NHS staff and wellbeing services and the appointment of a Board level executive champion for staff health and wellbeing in each NHS organisation. It is vital this senior leader has - as suggested - arrangements for supporting and enabling line managers to support staff and tackle their health and wellbeing issues. Again, we believe this will be most effective if it is a supportive rather than punitive approach, seeking to embed psychological wellbeing (including supervisor and co-worker support in a supportive organisational climate) as part of an organisation's core business. The mechanism for delivery of this could be through local work wellbeing champions that have patient-centred care as their core mission together with high support for staff wellbeing at work.

The five high impact actions developed by the Department of Health's Wellbeing Delivery Group to embed staff health and wellbeing within NHS organisations (see page 52 in Chapter 2) are ambitious, but it is essential

that these initiatives are used to do more than decrease absenteeism and presenteeism, important though these are. In the current economic climate there could be a danger that boards will use OH departments as a 'sickness surveillance' service and for presenteeism to increase. As currently framed there is nothing to stop the high impact actions being interpreted in this way.

It is therefore critical to embed a proactive approach to the psychological health of employees and their satisfaction with work but also important that staff wellbeing, framed broadly as in this study, is seen as central to the delivery of high quality care for patients.

10.7 Key messages for patients, carers and relatives

This section presents the key messages for patients, carers and relatives. We welcome any feedback from you about the study and our findings. If you would like to comment or make any suggestions about this research please send these to the principal investigator Professor Jill Maben at the address shown at the beginning of the report.

- Patients should expect their care and their interactions with doctors, nurses and other healthcare staff to be positive and supportive.
- Patients sometimes do not have the opportunity, or feel able, to directly question staff about poor care and poor caring behaviours. Patients who feel concerned about their care, or would like to make suggestions for how patient experiences can be improved, should contact the service manager or the Patient Advice and Liaison Services (PALS) at the organisation where they were treated. PALS can help you to explain the problem and to make sure the right people in charge hear your views.
- Some older patients are very frail and may not be able to recall details of the services provided to them. Carers and relatives can help to convey their experiences of care on their behalf. Some young people, people with special communication needs, or learning disability also need help to make sure their views are heard.
- Many patients value 'relational' aspects of care – this means staff communicate well and connect with them as individual people and understand their specific situation and needs. Staff also need to provide care that is efficient so patients should try to explain clearly to staff what is important to them, ask questions about their care and discuss what they feel is best for them.
- Patients should be aware that poor staff wellbeing can lead to poor patient care. It is in everyone's interests that staff are motivated and happy in their work. Patients say they have good experiences of care when staff work as part of a supportive team/group, work well with co-workers, express job satisfaction, feel their organisations are positive and supportive, have low emotional exhaustion, and supervisor support.
- Patients should be aware that improving staff wellbeing is likely to result in better patient experiences. It is important for staff to spend

time away from care environments to go on training, to attend skills development courses and to be supervised by a senior colleague.

- Patients, carers and relatives have a very important role in helping to improve health services. Patients can help by feeding back about their care, such as completing a patient experience survey, writing comments for a suggestion box or talking to staff. Patients can also get more involved in their local health services as patient representatives, or by joining a patient or carer organisation to lobby for change.
- Patients, carers and relatives can make a difference by getting involved in research. The organisation People in Research (www.peopleinresearch.org) can connect you with researchers working on topics that matter to you. It is likely that you will be offered payment for your time.
- Patients and carers can help to educate healthcare professionals. It is important that healthcare professionals learn how to engage with individual patients and understand different aspects of patient experience. Patients and carers can help by contacting their local college or university and becoming involved as patient teachers. This is sometimes done on a voluntary basis or may be paid.

10.8 Key messages for patient and carer organisations

The following section looks at what the key messages of this research are for patient and carer organisations. The executive summary of this report provides a useful overview of the aims, methods and key findings of the study. Members of patient and carer organisations may wish to share this information with their members. We have also written a short summary of the study suitable for patient and carer organisations to include in their newsletter or website – if you would like a copy please contact us and we welcome any feedback from you about the study and our findings.

- Patient and carer organisations should lend their support to investments and initiatives that lead to improvements in staff wellbeing because they are likely to lead to improvements in patient experiences of care.
- Patient and carer organisations can lend their support to campaigns to address staff shortages and to reduce pressure on staff. Excessive demands on staff can be detrimental to both staff wellbeing and patient care. Staff who are exhausted do not provide a good service to patients.
- Patient and carer organisations are right to advocate putting patients first. Staff teams that focus on providing patient-centre care with the encouragement and backing of leaders report higher levels of wellbeing and ability to care for patients.
- Staff who feel in control of their work – for example they have the right skills, competence and are dedicated to their work – can help to deal with high demands and exhaustion leading to better patient care. Patient and carer organisations can help make sure staff have the right type of skills and knowledge by contributing to the

development of professional competency frameworks such as the Nursing and Midwifery Council and General Medical Council.

- Patient and carer organisations can help to improve patient experiences of care by offering their support to patient assessments of care at local health care organisations.
- Patient and carer organisations can offer valuable perspectives to future research about the meaning of patient experience for different groups of people. There is a need to develop better ways of measuring, assessing and reporting on patient experiences of care. We suggest a key area for future research is to try to improve patient experience through improving staff wellbeing.
- Patient and carer organisations can help make research more accessible to more people. Some older people, younger people, people with communication needs or learning disability need extra help and support to understand the importance of their views and to share them with researchers. They may also need help to understand the findings of research and what it means for them.

Appendix 1 Recommendations from the Boorman review

Improving organisational behaviours and performance:

- We recommend that all NHS organisations provide staff health and wellbeing services that are centred on prevention (of both work-related and lifestyle-influenced ill-health), are fully aligned with wider public health policies and initiatives, and are seen as a real and tangible benefit of working in the NHS.
- We recommend that all NHS leaders and managers are developed and equipped to recognise the link between staff health and wellbeing and organisational performance and that their actions are judged in terms of whether they contribute to or undermine staff health and wellbeing.
- We recommend that all NHS Trusts develop and implement strategies for actively improving the health and wellbeing of their workforce, and particularly for tackling the major health and lifestyle issues that affect their staff and the wider population.
- All NHS Trusts should implement the guidance both from the National Institute for Health and Clinical Excellence (NICE) on promoting mental health and wellbeing at work and from the National Mental Health and Employment Strategy.
- It is essential that all NHS Trusts put staff health and wellbeing at the heart of their work, with a clearly identified board-level champion and senior managerial support.
- Training in health and wellbeing should be an integral part of management training and leadership development at local, regional and national levels and should be built into annual performance assessment and personal development planning processes.
- We believe that high priority should be given to ensuring that managers have the skills and tools to support staff with mental health problems.

Achieving an exemplar service:

- We recommend that, when drawing up a staff health and wellbeing strategy, Trusts undertake a proper assessment of key health priorities and risk factors, which should fully reflect their legal requirements in this area.
- We recommend that there should be consistent access to early and effective interventions for common musculoskeletal and mental

health problems in all Trusts, as they are the major causes of ill-health among NHS staff.

- We recommend that, as well as providing core staff health and wellbeing services to nationally specified standards, all Trusts should provide a range of additional staff health and wellbeing services targeted at the needs of their organisation. To do this they will need both to assess the specific needs and requirements of their staff and to engage with staff to determine the services they wish to see provided.
- Staff engagement will be critical to ensuring that both the range of services and the way in which they are provided are seen as credible and to addressing staff concerns. Trusts need to go beyond simply meeting their legislative obligations to embrace a wider concept of staff engagement.
- It is essential that staff health and wellbeing services commissioned following the sort of risk assessment process we have outlined are then properly resourced.
- Core early intervention services should form part of the minimum service specification for staff health and wellbeing recommended in our earlier report.
- There should also be nationally agreed service standards for early intervention (paragraph 3.11).

Embedding staff health and wellbeing in NHS systems and infrastructure:

- We now recommend that the NHS Operating Framework should clearly establish the requirement for staff health and wellbeing to be included in national and local governance frameworks to ensure proper board accountability for its implementation.
- We recommend that the Care Quality Commission's annual assessment of NHS organisations and their delivery partners should in future include standards and targets for staff health and wellbeing. Similarly, Monitor should consider support for staff health and wellbeing in its assessment process for Foundation Trust status as well as in its in-year monitoring arrangements.
- It is important that the approach to improving support for staff health and wellbeing is developed in consultation and partnership with staff and trade unions.
- We recommend that all NHS organisations put in place a staff health and wellbeing strategy developed with the full involvement of staff and staff representatives, and that its implementation is routinely monitored, reported and discussed with staff and their representatives.

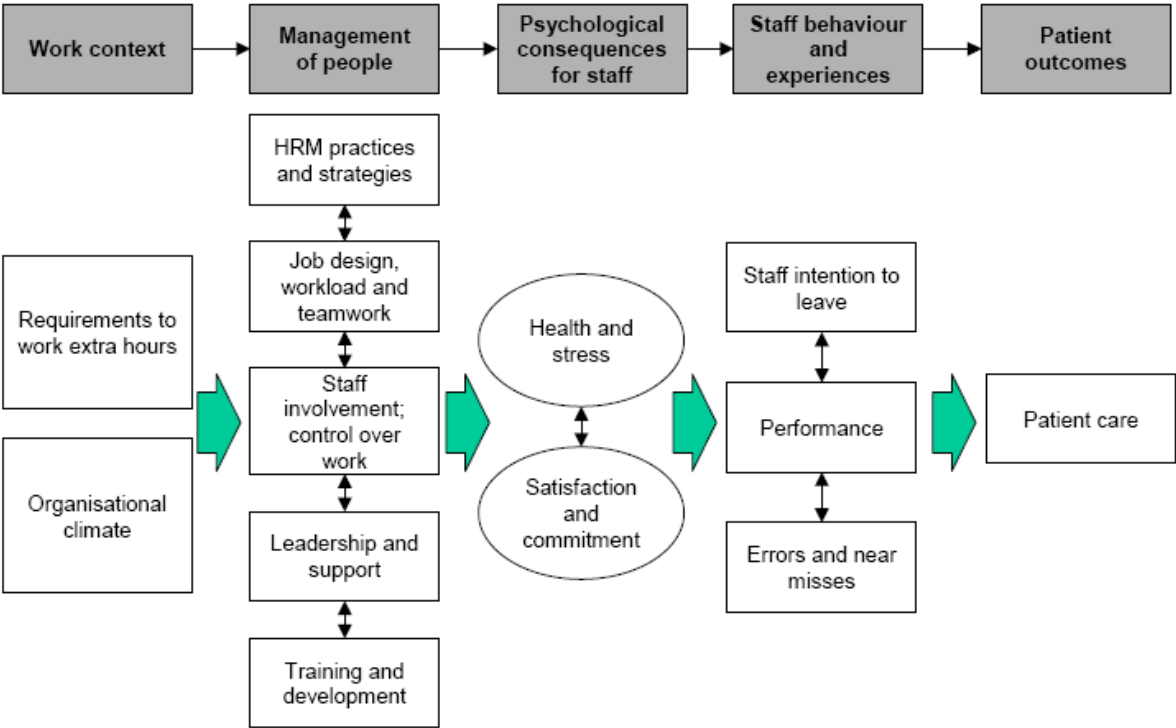
- It is essential that staff health and wellbeing strategies, and the services that are subsequently commissioned, are available to all staff on an equitable basis.
- It is also important that delivery of staff health and wellbeing services is properly monitored and regularly assessed and reviewed.

Source: Boorman S. (2009) Health and Wellbeing. Final Report. Department of Health; London

Appendix 2 Measuring staff wellbeing in the NHS

Beginning in 2003, the NHS staff survey was structured around a model of the links between the environments staff work in (work context), management of people, staff behaviour and experiences and patient outcomes (Figure 34). The model - developed originally for the Healthcare Commission by Dr. Susan Michie, University College London and Professor Michael West, Aston Business School - and the evidence described by Michie and West underpinned the development of the staff survey with the aim of ensuring that it was evidence based, comprehensive and directly relevant to staff and organisational performance, and thereby patient care, within the NHS.

Figure 34. An architecture for understanding the links between the context of work, management of people practices, psychological consequences for staff, staff behaviour and performance, and employee health, performance and patient care in the NHS



Source: Michie, S. and West, M. A., 2002 (349)

The research evidence and theory underpinning the staff survey model have been summarised elsewhere (42) and suggests that overall work context, people management, psychological consequences for staff and staff experience are highly influential in influencing employee health and

wellbeing but they also have a large effect on individual, group and organisational performance, and thereby patient care and patient outcomes. Those responsible for developing the NHS staff survey argued that there is therefore substantial empirical support for a policy focus on people management and human resource management practices in NHS organisations.

Appendix 3 Scoping review: Empirical studies linking staff wellbeing and patient experience in the healthcare sector

Aim

To review empirical studies in the healthcare sector that have explicitly sought to explore the link between staff wellbeing and patient experience.

Methods

Inclusion/exclusion criteria

To be eligible for inclusion, papers needed to be empirical studies which explicitly sought to directly explore the link between staff wellbeing and patient experience in the healthcare sector. We were aware of the risk that the number of downloaded references from electronic searches in a topic area such as this might be very high. We therefore excluded studies that focused solely on a particular aspect of staff wellbeing (such as burnout) or of patient experience (such as patient satisfaction) if they did not seek to make a direct link between the two; the number of such studies would have been unmanageable in the context of the scoping review for this study (although we of course drew on seminal reviews and studies of staff wellbeing or patient experience for developing our theoretical framework and measures of key variables in the staff and patient surveys). For pragmatic reasons we further limited our review to literature published in English, although we are aware that this may have resulted in a significant language bias.

Our broad focus on 'staff wellbeing' and 'patient experience' presented difficulties as we needed to include a high number of studies published in a wide range of different literatures as well as using various definitions of 'staff wellbeing' and 'patient experience' (see 'search strategy' below). For this reason it was problematic to identify the studies exploring a direct link between the two concepts and time-consuming to review them. Whilst our scoping review is therefore based on a broad literature, we are aware that our review may not have comprehensively covered all relevant studies and that there is, of course, an even broader literature outside the healthcare sector covering 'employee wellbeing' and 'customer satisfaction'. This has not been reviewed here but, again, has informed the development of our survey tools.

Search strategy

Our scoping review includes the core qualitative as well as quantitative studies published with a stated purpose of exploring the link between staff wellbeing and patient experience. Searches across four electronic databases - as detailed below - were a first step to ensure that the review covers a significant proportion of published research. We tailored our search strategies for each electronic database to include both 'employee wellbeing at work' and 'patient experience' related terms. Table 22 gives the details of our individual search strategy for each database. The following tables define search terms for each database. These include a mix of subject heading terms (MeSH terms followed by /) and keywords (followed by .mp.) found in the full citation, title, or abstract.

Table 22. Search strategies in various databases

British Nursing Index and Archive 1985 to July 2011:

Staff wellbeing	health personnel attitude/ or nurse patient relationship/ or job satisfaction/ or psychological aspect/ or wellbeing.mp. or occupational health/ or motivation/ or emotional exhaustion/ or burnout.mp. or depression.mp.	6056
Patient Experience	Nurse Patient Relations/ or Patients : Psychology/ or "Patients : Attitudes and Perceptions"/ or "Pain and Pain Management"/ or consumer satisfaction/ or patient satisfaction.mp. or patient experience.mp. or patient care.mp. or patient safety.mp.	20808
		811

EMBASE 1980 to 2011 Week 27:

Staff wellbeing	nursing staff/ or medical staff/ or staff/ or employee attitude/ or employee/	79390
	health personnel attitude/ or nurse patient relationship/ or job satisfaction/ or psychological aspect/ or wellbeing.mp. or occupational health/ or motivation/ or emotional exhaustion/ or burnout.mp. or depression.mp.	267712
Patient Experience	patient care/ or patient satisfaction/ or experience/ or patient attitude/ or patient experience.mp.	826201
Empirical studies		1820

English language		1624
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HMIC Health Management Information Consortium 1979 to May 2011 :

Staff wellbeing	health personnel attitude/ or nurse patient relationship/ or job satisfaction/ or psychological aspect/ or wellbeing.mp. or occupational health/ or motivation/ or emotional exhaustion/ or burnout.mp. or depression.mp.	6201
Patient Experience	Nurse Patient Relations/ or Patients : Psychology/ or "Patients : Attitudes and Perceptions"/ or "Pain and Pain Management"/ or consumer satisfaction/ or patient satisfaction.mp. or patient experience.mp. or patient care.mp. or patient safety.mp.	191319
Empirical study	(article)	230

Ovid Medline(R) 1948 to June Week 5 2011:

Staff wellbeing	Nursing Staff, Hospital/ or Staff Development/ or Medical Staff, Hospital/ or Medical Staff/ or Nursing Staff/	71769
	Interprofessional Relations/ or Burnout, Professional/ or Mental Disorders/ or Stress, Psychological/ or Job Satisfaction/ or Social Environment/ or Anxiety Disorders/ or wellbeing.mp. or emotional exhaustion.mp. or motivation.mp.	331451
Patient Experience	Patient Satisfaction/ or Patient Care/ or patient experience.mp. or clinical care.mp. or patient safety.mp.	68060
Empirical studies	(case reports or classical article or clinical trial or comparative study or consensus development conference or controlled clinical trial or evaluation studies or journal article or meta analysis or multicenter study or randomized controlled trial or "review").pt.	18106935
		364

We anticipated that locating research studies relevant to our review would be a challenge, due to the broad scope of the review and the poor indexing

of qualitative research. For this reason we used additional strategies for searching the literature.

In order to further increase the comprehensiveness of the search we also undertook the following:

- (a) Reviewed references cited by three key research papers (Michie, S. and West M. 'Managing People and Performance: An Evidence Based Framework Applied to Health Service Organisations'. *International Journal of Management Review*, 2004. 5/6(2): 91-111; Firth Cozens, J., Greenhalgh, J. 'Doctors' perceptions of the links between stress and lowered clinical care'. *Social Science and Medicine* 1997; 44 (7): 1017-1022; and Raleigh, V., Hussey, D., Seccombe, I. and Qi, R. 'Do associations between staff and inpatient feedback have the potential for improving patient experience? An analysis of surveys in NHS acute trusts in England'. *Quality and Safety in Health Care*, 18 (5) 2009, 347-354) by using the ISI Web of Knowledge.
- (b) For the duration of the study members of the research team compiled an 'Endnote' database on an ongoing basis. This was populated by references members of the research team were already aware of or had been pointed towards by colleagues or experts in the field.

These two further strategies helped us to locate additional studies to supplement the electronic searches. Other literature reviews in complex topic areas - for example, a review of diffusion of service-led innovations (Greenhalgh T., and Peacock, R. Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources. *BMJ* 2005; 331: 1064) found that higher yields of relevant articles, in relation to researcher time, came from methods that were not 'protocol driven'.

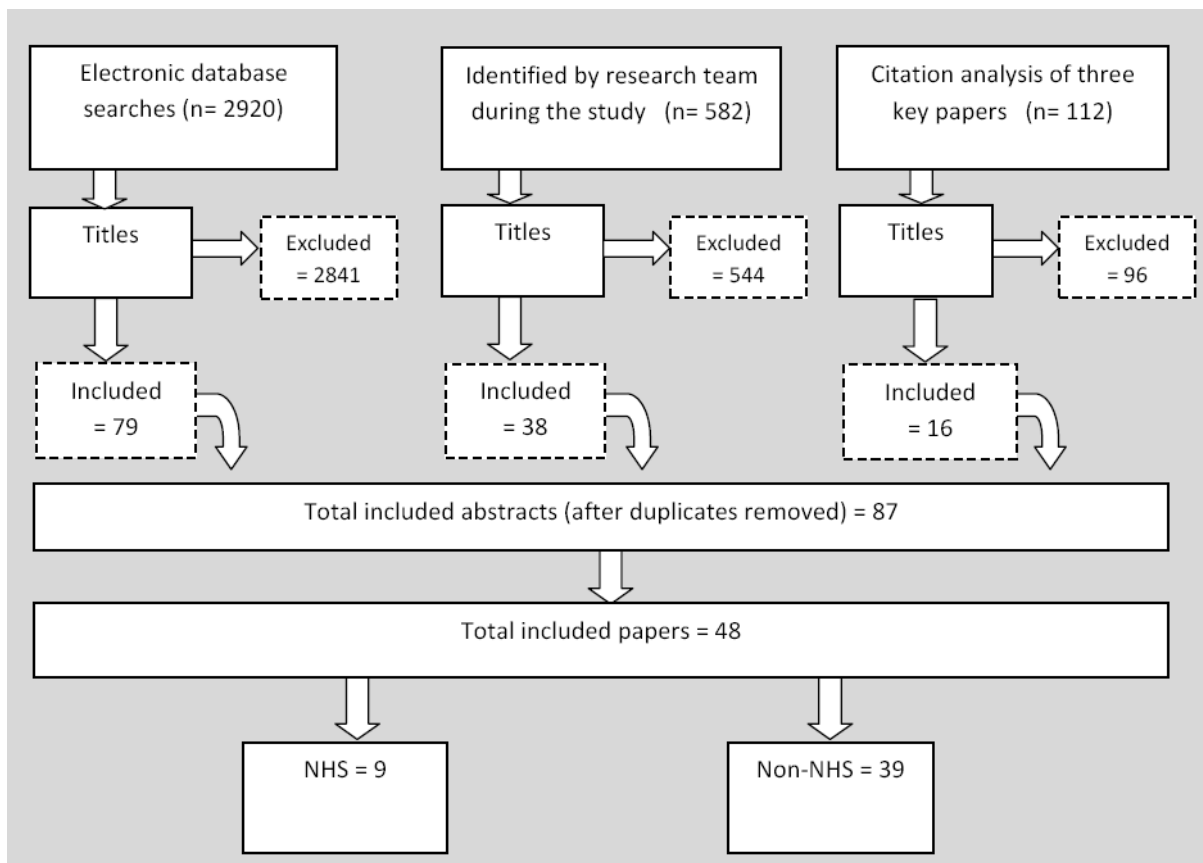
Search results

Our electronic searches identified a total of 2,920 potentially relevant references on the four databases we searched (see Figure 35). Additionally, we identified 112 potentially relevant publications through citation analysis of the three key papers named above. At the time of our review the research team's 'Endnote' database comprised 582 references. Following removal of duplicate references and a review of the title of each paper by one member of the research team (GR), we selected 87 studies to include in a first stage review. After excluding 38 papers on the basis of their abstracts we finally included 48 references. Of these, 9 studies had been undertaken in the NHS in England and 39 were undertaken in another country (including Robertson et al.'s 1995 study of nurses working in psychiatric units in NHS Scotland).

Tabulating and analysing the data

Data from each of the 39 studies that met our inclusion criteria were extracted by one researcher. For each included paper we recorded, first of all, the first author name and year of publication; secondly, the research aim; thirdly, the study setting; fourthly, the methods used; fifthly, the key findings; and, finally, comments on the nature of the link between staff wellbeing and patient experience that was explored.

Figure 35. Included papers



Appendix 4 Summary of empirical studies of emotional labour in healthcare

Author	Aim	Setting	Method(s)	Key findings	Comments
Bolton (2000) (158)	To learn how nurses feel the introduction of 'new' management has affected their work, particularly as they present themselves to patients.	A gynaecology unit in a large NHS hospital in the North of England (1980's).	Ethnographic fieldwork with semi-structured interviews and follow-up interviews in gynaecology wards and out-patients clinics. All grades of nursing staff interviewed on one unit.	Argues that notion of 'emotional labour' of nursing over simplifies the motivations, emotional complexity and contextual aspects of nurses' work. Identifies the altruistic (if selective) relationship that motivates nurses' emotional labour. Nurses' skills reside in the balance achieved in relationships of emotional involvement with patients and 'professional feeling rules' of detachment. Identifies the felt tension between 'creative altruism' and 'market mentality' within nursing care.	Emphasis on complexity of emotions involved in nursing care, which may be oversimplified by defining care practices as 'emotional labour'.
Bolton (2001) (157)	Descriptive and interpretive study of nurses' commentaries of, and activities with, patients.	A group of nurses working on one unit in a NHS hospital in the North of England (1980's).	Semi-structured interviews with 10 nurses. Conversations and observations involving 35 nurses of various grades and lengths of service.	Describes three 'faces' of the nurse (professional, smiley, humorous) to show how, against the backdrop of structural changes in the public health sector, nurses manipulate and resist emotional demands.	Nurses draw on their knowledge and moral perspectives to inform emotional encounters and interactions with patients.
Bolton (2002) (159)	Examines the effects of 'new' public sector management on professional nursing work.	Two surgical wards and associated out-patient clinics in one north west hospital (early/mid 1990s).	Ethnographic study of nurses at ward level. Qualitative data used in this discussion collected as part of longitudinal study with fieldwork conducted over six years, semi-structured interviews and observational work was undertaken on wards	Identifies nurses as 'those who shape the interface between patient and the hospital' and nursing as 'a target for management's cost-cutting and quality initiatives'. Nurses feel expectations for customer satisfaction and cost reduction. Nurses feel tension between consumer	Draws attention to negative incidents of potential violence and verbal abuse towards nurses in the context of healthcare cost-cutting.

Author	Aim	Setting	Method(s)	Key findings	Comments
			and out-patient clinics.	power and professional responsibility for care Nurses resist the 'forced niceness' versus 'authentic caring behaviours'	
Bolton (2007) (111)	Aims to demonstrate what is understood about the power and structural effects of emotion and identity in organisations. Examines the influence of workplace cultures, power, and institutional expectations, while also exploring the negative impacts of emotion management in the workplace.	An NHS hospital ward where the author was a patient, observer and conversant with front-line staff.	Personal narrative situated within review of modern sociological literature on relationship between emotion and work.	Argues 'crafted emotion' is sometimes contrived and sometimes integral to nurses' work. Identifies nurses as different from other front-line service workers because of complex work and motivations. Suggests that 'professional demeanour' is an important dimension of wellbeing allowing distance from distressing and over-demanding aspects of caring. Suggests that 'professional rules of nursing' dictate that emotion should not be shown, but the implicit rules of nursing communities allow peer support.	Drawing from Goffman's (1961) (350) important thesis on emotion workers, highlights the interpersonal and emotional dimensions of hospital ward work and care relationships Cites extensive literature on use of humour in nursing practice.
Diefendorff et al. (2011 (160))	To examine display rules and emotional regulation at a unit level.	Registered nurses working in different units of a hospital system.		Evidence that display rules can be represented as shared, unit-level beliefs. Controlling for the influence of dispositional affectivity, individual-level display rule perceptions, and emotion regulation, unit-level display rules are associated with individual-level job satisfaction. Unit-level display rules relate to burnout indirectly through individual-level display rule perceptions and emotion regulation strategies. Unit-level display rules also interacted with individual-level dispositional affectivity to predict employee use of emotion regulation strategies.	Evidence that display rules and emotional regulation operate at unit level.

Author	Aim	Setting	Method(s)	Key findings	Comments
Fulton (2008) (167)	To examine differences in nurse-patient interactions (defensiveness) in different care settings of a hospital.	Two acute care settings (surgery and haematology) in a large teaching hospital.	Qualitative study using observational techniques of nurse-patient interactions.	There was close nurse/patient involvement on the haematology unit, but on acute surgery involvement was prevented by nurses taking a distanced stance. The difference is explained as organisation systems of units where nurses (along with other professional staff) develop the skills to deal with patient's emotional needs.	Indicates, but does not fully explore, the emotional qualities of staff interrelationships.
Gray (2009a) (146)	To examine the role of emotional labour in nursing.	A qualitative study conducted over a period of 12 months.	Data were collected primarily from 16 in-depth and semi-structured interviews with nurses. Key themes elicited at interviews touch upon diverse topics in the emotional labour of nursing.	Presents nurse definitions of emotional labour; the routine aspects of emotional labour in nursing; traditional and modern images of nursing; and gender and professional barriers that involve emotional labour in health work. Understanding emotional labour is important for improving nurse training and best practice.	Highlights potential therapeutic value of emotional labour and implications for work environments.
Gray (2009b) (351))	Focuses on examining nurses' definitions and experiences of emotional labour.	Qualified student nurses.	Qualified and student nurses were interviewed about their understanding of emotional labour as part of the nurse-patient routine, their perceptions of its value, its association with traditional images of nursing and gender roles within caring and the lack of interprofessional recognition.	Participants identified gender and professional barriers regarding the recognition of emotional labour. They also identified interprofessional barriers to providing emotional labour.	Identifies gender and interprofessional barriers to providing emotional labour.
Gray and Smith (2008) (171)	This study applied the notion of emotional labour to the study of student nursing.	Data were collected from 16 in-depth and semi-structured interviews with nurses based in East London UK.	A qualitative study was conducted over a period of twelve months to re-examine the role of emotional labour and in particular the ways in which emotional labour was orientated to different clinical	Findings illustrate emotional labour in three different settings (primary care, mental health and children's oncology). Findings show the different ways in which emotional labour is used and reflected upon by nurses in these three clinical areas. This is important in	

Author	Aim	Setting	Method(s)	Key findings	Comments
			settings.	improving nurse training and best practice as well as helpful in offering an initial synopsis of the culture of care in nursing; investigating several clinical settings of nurses' emotional labour; looking at changing techniques of patient consultation; and beginning to explore the potential therapeutic value of emotional labour.	
Halliday (2008) (110)	Investigates the views of midwives on the significance of their work in the context of patient-centred service innovation.	Patient-centred service innovation in NHS hospital and community midwifery services in one southern county of the UK (late 1990s).	Semi-structured interviews with 15 midwives followed by focus group discussions.	Identifies a shared mythology amongst midwives of a lost professional autonomy and wisdom. Highlights tensions between professional identity and organisation reform in health services	Reconfirms that health care aspirations and relationships (between staff and patients) are mediated by employing organisations and professional mythologies/claims to identity.
Haycock-Stuart (2010) (172)	The focus of this paper aims to examine emotions in leadership, particularly collegial emotional labour within community nursing.	12 leaders of community nursing.	Qualitative interviews	The nurse leaders indicated how they undertook surface acting to mask their emotions, to maintain a dignified and professional demeanour with colleagues. Interviews with nurse leaders highlighted the tensions in their roles and that they often felt unsupported. Few community nurse leaders had access to emotional support in their leadership role unless they became stressed and unwell.	Recommends that support through coaching or mentorship should be made available for people in leadership positions whatever their level.
Henderson (2001) (352)	The findings presented in this paper constitute one aspect of a larger qualitative study which focused on nurses' approaches to the care of abused women.	Forty-nine nurses from two countries (Canada and the United Kingdom) working in four different clinical areas (emergency, community health, community mental health, and maternity) were interviewed, both in a focus group and individually.	Social constructivist approach. Eight focus group interviews were conducted with groups of six to nine nurses: one interview in each of the four clinical areas in both countries. The underlying intent of the focus group interview was to elicit information about	In this study nurses held a variety of different views about the value of detachment (objectivity) versus engagement (subjectivity) as applied to the nursing care of patients. These views seemed tied to their views of self. Most nurses did not see engagement/detachment as being so clearly residing in the individual.	Ambiguity about the 'proper' use of emotional engagement/detachment in different contexts and circumstances of patient/nurse encounters.

Author	Aim	Setting	Method(s)	Key findings	Comments
			the nurses' approaches to care of women whom they either knew or suspected to be abused. Thus the focus was on nursing work, clinical setting, client characteristics and beliefs about practice.	Generally there was a sense of being on a continuum along which one moved, in response to specific patients or circumstances, as they required or demanded differing degrees of engagement or detachment. Nurses held differing opinions on the 'proper' use of emotional engagement versus emotional detachment in caring work.	
Hülshager and Schewe (2011) (161)	Provides a quantitative review of the link of emotional labour (emotion-rule dissonance, surface acting, and deep acting) with wellbeing and performance outcomes.	Review of 95 research studies on emotional labour.	Meta-analysis based on 494 individual correlations drawn from a final sample of 95 independent studies.	Substantial relationships of emotion-rule dissonance and surface acting with indicators of impaired wellbeing and job attitudes and a small negative relationship with performance outcomes. Deep acting displayed weak relationships with indicators of impaired wellbeing and job attitudes but positive relationships with emotional performance and customer satisfaction. Surface acting partially mediates the relationship of emotion-rule dissonance with wellbeing.	Draws links between deep acting (practicing with empathy) and wellbeing.
James (1992) (109)	To explore the concepts of carework from the perspectives of hospice nurses.	Carework of hospice nurses compared to carework in domestic settings.	The formula 'care = organisation + physical labour + emotional labour' identifies component parts of 'carework' as they were observed at a hospice. A comparison between women's domestic carework and that of the hospice nurses is made firstly to clarify the component elements of care and secondly to show how the	It is argued that family care has been a model for hospice care but that division of labour in hospices, which replicates hospital labour-divisions, results in inflexibility in hospice care which is incompatible with the 'family' model. It is suggested that emotional labour is likely to be increasingly recognised as part of health care but that the concept of 'total care' needs to be questioned.	Highlights how emotional labour is affected by the division of labour in different healthcare settings.

Author	Aim	Setting	Method(s)	Key findings	Comments
			interrelation and balance of the components differs in the two settings.		
Katayama (2010) (162)	To clarify the effects of factors of emotional labor, defined as the suppression of own emotions to better maintain other peoples' emotional conditions, on job-related stress responses among hospital nurses, the relationship between emotional labor and job-related stress was analyzed.	147 nurses of five hospitals in Japan.	A self-reported questionnaire was distributed to nurses. Complete answers were collected from 123 nurses. Emotional labor was assessed by the Emotional Labor Inventory for Nurses (ELIN) (26 items), which consisted of five subscales, i.e., "suppressed expression," "surface adjustment," "deep adjustment," "exploring and understanding" and "expression on caring." Job-related stress was evaluated using the Brief Job Stress Questionnaire (BSQ) consisting of 57 items.	Nurses working in an inpatient department showed significantly higher total ELIN scores than those working in an outpatient department. Scores on "anger" and "fatigue" in BSQ positively related to "suppressed expression" scores in ELIN; those on "anxiety" positively related to "deep adjustment" scores; and those on "depression" positively related to "surface adjustment" scores. Similarly, scores on negative stress responses (BSQ) such as "anger," "fatigue," "anxiety," "depression," and "somatic stress responses" positively related to scores on job stressors (BSQ), e.g., physical work load, whereas "vigor" scores positively related to "job worthwhileness" in BSQ.	Suppressed expression, deep adjustment, and surface adjustment of emotional labor seem to be the major occupational stressors for nurses, as well as job-related stressors.
Reeves & Lewin (2004) (105)	To examine how health professionals collaborate and the meanings they give to 'collaborative work'	Two general medical wards in a large inner-city teaching hospital in the south of England.	Mapped expectations and practices of intra and interprofessional collaboration on two hospital wards. Ethnographic approach (3 months of in-depth study of day-to-day assumptions and activity) through observational and conversational data, and group and individual interviews (n=49).	Highlighted the centrality of nurse-doctor relations to collaborative hospital ward work (cf. Patel et. al 2000) but also the structural and professional barriers to collaboration. Described the differing views of doctors and nurses of collaborative work. Nurses use more humour, physical contact/intimacy with other nurses. Relational aspects of work (such as creating team) are often perceived as private (feminine activities) that 'stand outside of the definition of work and competence' (Fletcher 1998)	Implies that more personalised professional working relationships on hospital wards, sustained through time, small talk and humour, promotes teamwork and collaboration.

Author	Aim	Setting	Method(s)	Key findings	Comments
Rose and Glass (2010) (164)	To examine community nurses' experiences of providing palliative care in the home.	Australian community nurses.	Qualitative research. Emancipatory methodology was used to explore the interconnections between nurses' emotional labour in palliative care provision, their stress levels, emotional wellbeing and self-care, and their professional practice.	Nurses working in the community require support, clinical supervision and professional development to support emotional labour and emotional wellbeing.	Draws some links between emotional labour, stress and wellbeing.
Smith and Gray (2001) (168)	This article describes part of a follow-up study to Smith's (1992) original work on emotional labour, at a time when questions of the role, scope and crisis in nursing are a matter of local and national debate.	Examines effects of changes in nursing and nurse education as a means of exploring new patterns of learning to care in nursing. The role of the link lecturer, and mentor who shape the student nurse's learning experience, is the focus for evaluation. The study used an opportunistic and purposive sample of subjects and settings. Sixteen people were interviewed which included students from the first, second and third years of training; seven qualified nurses and two general practitioners.	6-month pilot study which draws from the traditions of empirical qualitative data collection, ethnomethodology and feminist methods in healthcare research. Data collection included: meetings and focus groups with lecturers, mentors, students, clinical staff and representatives from the Students' Council for Nursing. Eleven sample questionnaires on emotional labour and 16 sample questionnaires on images of nursing, completed by student nurses. Participant and non-participant observation during student nurse classes.	Mentors and link lecturers were frequently described as students' chief role models for learning to care and the main providers of emotional labour and support. None of the nurse respondents discounted emotional labour from the work they did in clinical and non-clinical settings. Many nurses said that they had to be 'tuned in' to their own and perhaps more importantly the patient's emotions. When emotional labour operated as part of individualised routine care, it also helped the nurse to get to know the patient through more informal relations and maintain the everyday running of the ward. Reflective learning was itself seen as an emotional labour.	Student nurses learn about emotional aspects of caring through role models. Reflective practice is itself perceived as emotional labour.
Smith et al. (2009) (173)	This paper sets the discussion of emotions at work within the modern NHS and the current prioritisation of creating a safety culture within the service.	The paper focuses on the work of students, front-line nurses and their managers drawing on recent studies of patient safety in the curriculum, and governance and incentives in the care of patients with complex long term	The primary research featured in the paper combined a case study design with focus groups, interviews and observation.	The recognition of emotions and the importance of emotional labour at an individual and organisational level managed by emotionally intelligent leaders played an important role in promoting worker and patient safety and reducing workplace risk.	Suggests nurse managers need support to understand the emotional complexities of the organisations they work within.

Author	Aim	Setting	Method(s)	Key findings	Comments
		conditions.		Nurse managers need to be aware of the emotional complexities of their organisations in order to set up systems to support the emotional wellbeing of professionals and users which in turn ensures safety and reduces risk.	
Staden (1998) (153)	This study aims to recognize and value emotional labour and the skills involved and embodied within it. Also, there is an attempt to deliberately re-value the caring component of nursing.	Case studies of three experienced enrolled nurses (level 2) who were on a course to convert their nursing qualification to registered nurse (level 1) were compiled.	Phenomenology as an inductive, descriptive research method was used to investigate and describe their experiences as emotion managers at home and emotion workers in clinical hospital settings.	All three women recognize emotion work as work but also that this type of work is not recorded. They also were not able to name skills used for such work and generally believe that it is through life experience that they have learnt emotion management. All three women demonstrated a positive self-evaluation of their work although they felt that society did not value care work.	Argues for ways of improving and valuing the emotional labour of nursing.
Tyler & Ellison (1994) (174)	Investigated individual differences in perceived sources of stress, psychological wellbeing and coping styles in high-dependency areas of nursing.	Four high-dependency areas (theatres; the liver unit; haematology/oncology; elective surgery) in one large NHS hospital in central England.	Questionnaire survey of all nurses in the four identified units (response rate 43%; n=60) of various grades, ward types and length of experience. Follow-up interviews with 12 nurses (varying grades in four departments).	No significant difference in stress and coping styles in relation to gender or grade of nurses. However nurses with children and with partners (or ex-partners) report less stress at work (notably with interpersonal care). Nurses with post-qualifying training reported significantly more stress (due to lack of social support, heavy workload, conflict with doctors and other nurses) (cf. Dobson 1982). Reported stress levels were similar across the four departments but sources of stress varied, including death of a patient to administrative burden. Significant numbers of nurses are aware of risks of stress and employ adaptive coping techniques.	Recommends management skills training and training for reducing stress. Unclear how reported stress in these settings differs from other care settings. Unclear how stress relates to general health.
Yang and	Examines the	Teaching hospital in Taiwan.	Questionnaire survey	Emotional display rule (EDR) was	Some dimensions of emotional

Author	Aim	Setting	Method(s)	Key findings	Comments
Chang (2008) (163)	relationships between emotional labour, job satisfaction and organisational commitment from the perspective of nursing staff.			<p>significantly and negatively related to job satisfaction.</p> <p>Surface acting (SA) was not significantly related to job satisfaction but demonstrated a significantly negative relationship with organisational commitment.</p> <p>Deep acting (DA) significantly and positively correlated with job satisfaction but demonstrated no significance with organisational commitment.</p> <p>The variety of emotions required was not significantly related to job satisfaction; frequency and duration of interaction and negatively related to job satisfaction; and job satisfaction significantly and positively correlated with organisational commitment.</p>	labour (emotional display and deep acting) are positively related to job satisfaction.

Appendix 5 Empirical studies directly studying the link between staff wellbeing and patient experience in the NHS context

Author	Aim	Setting	Method(s)	Key findings	Comments
Edwards (2006) (101)	Analysis of perception gap between patient's and public views of the NHS	NHS patient experience data and staff experience data (data collected in 2005)	Quantitative analysis of Healthcare Commission and Picker Institute Surveys of Patient or staff and patient satisfaction national data.	Notable correlation between patients' perception of acute hospitals and a series of indicators concerning the detail of encounter between the patient and the system. The way that professionals behave, communicate and respond to the patient, and how the system backing them up is organised, are both crucial elements in how the service will be perceived. In all 'happy patients produce happier staff and vice versa' Suggests nurses and nursing have a key role to play in improving patient experience.	Identifies factors associated with reduced (nurse) staff turnover and burnout: higher staffing levels; higher educational levels; higher levels of autonomy of front-line staff; well developed teams; managerial support; well-designed work processes, HR policies and appraisal. Factors that reduce nurse staff turnover and burnout also associated with lower patient mortality. Suggests being able to be patient-focused gives job satisfaction, commitment and advocacy.
Firth-Cozens et al. (1997) (67)	To examine staff reported incidents of stress which have negatively affected patient care	225 hospital doctors and general practitioners in the NHS, 82 of who reported recent incidents where they considered that symptoms of stress had negatively affected their patient care	Categories of attributions were tiredness (mentioning tiredness, exhaustion, sleep deprivation); pressured by overwork (mentioning lack of time, lack of staff, hassle, etc.); anxiety or depression; the effects of alcohol; and boredom (all specifically referring to these). Categories of effects were: irritability/anger (impatience, violence, irritability); lowered standard of care (taking shortcuts, not following procedures); serious mistakes not leading to death (errors or accidents	Half of these effects (50%) concerned lowered standards of care; 40% were the expression of irritability or anger; 7% were serious mistakes which still avoided directly leading to death; and two resulted in patient death. Staff attributed the cause of stress to tiredness (57%) and the pressure of overwork (28%), followed by depression or anxiety (8%), and the effects of alcohol (5%).	Suggests strong links between staff reported stress and negative impact on patient care

Author	Aim	Setting	Method(s)	Key findings	Comments
			which had a negative effect on the patient); and patient death.		
Firth-Cozens (2001) (186)	Examines links between psychological health of doctors and the treatment of patients	Questionnaire study of 314 British trained medical students followed over 11 years	Follow-up of 11 year longitudinal study.	Self-criticism rather than empathy is a strong predictor of stress and depression. Self-criticism is a stronger predictor of stress and depression than work hours and work environment. The association between hours worked and stress levels are not clear because of interaction of perceived work demands; hours of sleep related to depression and impaired and cognitive performance. Overwork and lack of sleep causes poor care. However this compounds a cycle of guilt, stress and general declining quality.	Poor patient care and accidents due to stress are difficult to measure and many cases go unrecorded. Organisational factors influence stress (larger, less performance monitoring, less training and less work discretion contribute to stress).
Michie et al. (1996) (187)	To investigate the factors that contribute to the stress reported by nurses and patients	Nursing staff in one London teaching hospital	Thirty-four nurses in a London teaching hospital completed the nurse stress index and the Spielberger state trait anxiety inventory, and attitudes towards the ward and nursing care were measured in 52 patients	Nurses in the sample reported significantly greater problems than the norm in dealing with stress (as measured by the nurse stress index). In particular, they expressed difficulty in dealing with patients and their relatives, with conflict between home and work, and with and pressure resulting from problems concerning confidence and competence in the role. Patients were generally satisfied with the health care they received. There was a positive relationship between the time that patients spent talking to nurses and the degree to which nurses were perceived as helpful.	Nurses reported lower levels of confidence and competence during times of increased stress yet patient reported satisfaction was more closely linked to nurses spending time talking to patients.
Raleigh et al. (2009) (185)	To examine whether staff reported feedback on quality, safety	Survey data (collected in 2006) from 166 NHS acute hospitals in England. Responses to	Multiple linear regression analysis used to model the relationship between responses by 'front-line staff' and responses by patients using data at hospital level.	There were significant associations between staff and patient responses (i.e. negative staff experience reflected in poorer patient experience).	Although a link is evident it is unclear why and how staff feedback is associated with patient experience. Suggests

Author	Aim	Setting	Method(s)	Key findings	Comments
	and workforce issues reflects patient reported experiences.	survey: 69,500 staff and 81,000 patients. Analysis was restricted to responses of front-line staff.	Results were adjusted for location (London and non-London) and hospital type (teaching, acute, specialist).	Most notable association was availability of hand washing materials reported by staff positively associated with patient views on cleanliness. Other links were managerial support; staff witnessing and reporting potential errors (positively associated with patient experience); working extra hours and work related stress (negatively associated with patient experience). Patient experiences tended to be worse in London hospitals.	staff surveys indicate more general conditions while patient experiences tend to focus on quality and safety.
Raleigh et al. (2008)	Follow-up study to examine whether staff reported feedback on quality, safety and workforce issues is reflected in patient reported experiences	Survey data (2007) from 163 NHS acute hospitals in England. Analysis restricted to responses of front-line staff.	Multiple linear regression analysis used to model the relationship between responses by 'front-line staff' and responses by patients using data at hospital level. Results were adjusted for location (London and non-London) and hospital type (teaching, acute, specialist).	Positive staff feedback is strongly associated with good patient experience and vice versa. Staff intention to leave and harassment impact on patient experience. Poorer overall performance in London trusts and non-specialist trusts (as in 2006). Positive associations with patient wellbeing: handwashing materials; staff health and safety training; staff perceptions of effective action from employers towards harassment and violence. Negative associations to patient experience scores: staff using flexible working options; staff intention to leave; staff experiencing harassment, bullying or abuse; but also staff positive feeling towards organisation.	Highlights issues of staffing; factors external to healthcare; cultural and linguistic diversity as possible reasons for link.
Taylor et al. (2007) (60)	To determine the effect of consultant's mental health on patient care	Medical consultants working in UK NHS hospitals	Survey of 1794 UK NHS hospital consultants; 1308 (73%) responded.	Psychiatric morbidity (General Health Questionnaire-12 score ≥ 4) was present in 32% of responders, who were twice as likely to report drinking hazardous levels of alcohol, being irritable with patients and colleagues, reducing their standards of care and intending to retire early (all $P < 0.001$). Male and mid-aged consultants were also	Approaches that support consultants to practice medicine safely throughout their careers are required.

Author	Aim	Setting	Method(s)	Key findings	Comments
				particularly at risk.	
West et al. (2002) (188)	To explore the relationship between human resource management practices and organisational performance (including quality of care in health-care organisations)	Human resource (HR) directors from sixty-one acute hospitals in England	Questionnaires or interviews were used to explore HR practices and procedures. Data on patient mortality were also gathered.	Strong associations were found between HR practices and patient mortality generally. The extent and sophistication of appraisal in the hospitals was particularly strongly related, but there were links too with the sophistication of training for staff, and also with the percentages of staff working in teams.	HR practices, staff teamworking, training and appraisal all contributed to better organisational performance.
West et al. (2006) (353)	To examine the potential contribution of organisational behaviour theory and research by investigating the relationship between systems of human resource management (HRM) practices and effectiveness of patient care in hospitals.	52 hospitals in England		After controlling for prior mortality and other potentially confounding factors such as the ratio of doctors to patients, greater use of a complementary set of HRM practices has a statistically and practically significant relationship with patient mortality.	Suggests that managers and policy-makers should focus sharply on improving the functioning of relevant HR management systems in health care organisations as one important means by which to improve patient care

Appendix 6 Empirical studies directly studying the link between staff wellbeing and patient experience in the non-NHS context

Author	Aim	Setting	Method(s)	Key findings	Comments
Aiken et al. (2002a) (102)	To determine the association between the patient-to-nurse ratio and patient mortality, failure-to-rescue (deaths following complications) among surgical patients, and factors related to nurse retention.	Nurse staffing and patient outcomes in adult general hospitals (n=168) in Pennsylvania	Cross-sectional analyses of linked data from 10,184 staff nurses surveyed 232,342 general, orthopaedic and vascular surgery patients discharged from the hospital between April 1, 1998 and November 30, 1999, and administrative data from 168 nonfederal adult general hospitals in Pennsylvania.	After adjusting for patient and hospital characteristics (size, teaching status, and technology) each additional patient per nurse was associated with 7% increase in the likelihood of dying within 30 days of admission and a 7% increase in the odds of failure to rescue. After adjusting for nurse and hospital characteristics each additional patient per nurse was associated with 23% increase in the odds of burnout and 15% increase in the odds of job dissatisfaction.	In hospitals with high patient-to-nurse ratios, surgical patients have higher rates of mortality and nurses are more likely to experience burnout and job satisfaction.
Aiken et al. (2002b) (211)	To examine the effects of nurse staffing and organisational support for nursing care on nurses' dissatisfaction with their jobs, nurse burnout, and nurse reports of quality of patient care in an international sample of hospitals.	Adult acute-care hospitals in the U.S. (Pennsylvania), Canada (Ontario and British Columbia), England and Scotland.	Multisite cross-sectional survey involving 10,319 nurses working on medical and surgical units in 303 hospitals across the five jurisdictions.	Dissatisfaction, burnout and concerns about quality of care were common among hospital nurses in all five sites. Organisational/ managerial support for nursing had a pronounced effect on nurse dissatisfaction and burnout, and both organisational support for nursing and nurse staffing were directly, and independently, related to nurse-assessed quality of care. Multivariate results imply that nurse reports of low quality care were three times as likely in hospitals with low staffing and support for nurses as in hospitals with high staffing and support.	Nurse dissatisfaction and burnout are strongly linked to staff feeling supported and able to deliver high quality care.
Argentero et al. (2008) (195)	To explore the relationship between burnout in nephrologists and	Nephrologists (n = 68), nurses (n = 334), and hemodialyzed patients (n= 695)	Cross-sectional study of staff emotional exhaustion and patient satisfaction.	There was a significant positive correlation between staff personal accomplishment and client satisfaction (P < 0.01) and a significant negative correlation between staff emotional	Results suggest that high levels of burnout in physicians and nurses are associated with poor patient

Author	Aim	Setting	Method(s)	Key findings	Comments
	nurses and patient satisfaction with their care	from 10 dialysis centers across northern Italy.		exhaustion and patient satisfaction ($P < 0.01$). No significant correlation was found between staff depersonalization and patient satisfaction level.	satisfaction in dialysis units. Identifying and preventing staff burnout may increase patient satisfaction with health care.
Arnetz (2001) (219)	To investigate whether an association exists between staff experiences with violence and patient-rated quality of patient care.	Work environment and quality of care studies were carried out simultaneously at a single hospital in 1994, 1995, and again in 1997.	Six questionnaire studies, three concerning hospital staff's views of their work environment and three dealing with patients' perceptions of the quality of care, provided the data for evaluating the model. Regression analysis was used to see which combination of work environment and quality of care variables would best predict a positive overall grade for quality of care from the patient perspective.	Violence entered consistently as an important predictor into each of the three best regression equations for 1994, 1995, and 1997, respectively. The results of this analysis suggest that the violence experienced by health care staff is associated with lower patient ratings of the quality of care.	The study indicates that violence is not merely an occupational health issue, but may have significant implications for the quality of care provided.
Bacon et al. (2009) (221)	To examine the relationships between hospital context, nursing unit structure, and patient characteristics and patients' satisfaction with nursing care in hospitals.	The sample for this study was 2720 patients and 3718 Registered Nurses in 286 medical-surgical units in 146 U.S. hospitals.	Secondary data analysis of the Outcomes Research in Nursing Administration Project, a multi-site organisational study to investigate relationships among nurse staffing, organisational context and structure and patient outcomes.	Greater availability of nursing unit support services and higher levels of work engagement were associated with higher levels of patient satisfaction. Older age, better health status and better symptom management were also associated with higher levels of patient satisfaction.	Organisational factors in hospitals and nursing units, particularly support services on the nursing unit and mechanisms that foster nurses' work engagement and effective symptom management, are associated with higher patient satisfaction.
Bishop et al. (2008) (212)	To investigate (a) whether certified nursing assistants (CNAs) are more committed to nursing home jobs when they perceive their jobs as enhanced (greater autonomy, use of knowledge, teamwork),	Certified nursing assistants in 18 Massachusetts nursing homes.	Survey administered to 255 certified nursing assistants in 15 homes. A quality-of-life questionnaire was administered to 105 residents. Logistic regression accounting for clustering estimated the effect of personal characteristics, satisfaction with tangible job rewards, and aspects of job design on CNAs' intent to stay in current jobs. A general linear model estimated the effect of job	After accounting for satisfaction with wages, benefits, and advancement opportunities, good basic supervision was most important in affecting CNAs' intent to stay in their jobs. Job enhancements were not significantly related to intent to stay. Residents were more satisfied with their relationships to nursing staff and their quality of life on units where a higher proportion of CNAs were committed to their jobs.	Finding that greater job commitment of CNAs is associated with better quality of relationships and life for residents implies that better jobs lead to better care. Culture change that increases CNA autonomy, knowledge input, and teamwork may not increase workers'

Author	Aim	Setting	Method(s)	Key findings	Comments
	and (b) whether CNA job commitment affects resident satisfaction.		commitment on residents' satisfaction with their relationship to nursing staff.		commitment to jobs without improvements in basic supervision.
Clark et al. (2006) (193)	To explore the interrelationships between three categories of service quality in healthcare delivery organisations: patient, employee, and physician satisfaction.	Hospitals in the U.S.	The study uses national databases to compare the evaluations of hospital care by more than 2 million patients, 150,000 employees, and 40,000 physicians.	The results confirm the relationship connecting employees' satisfaction and loyalty to their patients' satisfaction and loyalty. Patients' satisfaction and loyalty were strongly associated with medical staff physicians' evaluations of overall satisfaction and loyalty to the hospital. Hospital employees' satisfaction and loyalty were related to the medical staff physicians' satisfaction with and loyalty to the hospital. Based upon the strength of the interrelationships, individual measures and subscales can serve as leverage points for improving linked outcomes. Patients, physicians, and employees, the three co-creators of health, agree on the evaluation of the quality of that service experience.	The results demonstrate that promoting patient-centeredness, enhancing medical staff relations, and improving the satisfaction and loyalty of employees are not necessarily three separate activities in competition for resources or leadership.
Cropanzano et al. (2003) (138)	To investigate the negative consequences of emotional exhaustion for individual employees and their employers.	Two hospitals in U.S.	Using social exchange theory the authors proposed that emotional exhaustion would predict job performance, 2 classes of organisational citizenship behaviour, and turnover intentions. In addition, the authors posited that the relationship between emotional exhaustion and effective work behaviours would be mediated by organisational commitment. These propositions were tested with data collected in two field studies in U.S. hospitals.	Emotional exhaustion did predict job performance, organisational citizenship behaviour, and turnover intentions. The relationship between emotional exhaustion and effective work behaviours was mediated by organisational commitment. Emotional exhaustion exerted an independent effect on these criterion variables beyond the impact of age, gender, and ethnicity.	Staff who are emotionally exhausted may feel they are not performing to their potential and disengage from the organisation.
DeVoe et al. (2007) (220)	To identify patients and physicians from similar geographic sites and to	National study in U.S.	Cross-sectional analysis of data from 3 rounds of the Community Tracking Study (CTS) Household and Physician Surveys	Satisfaction varied by region but was closely correlated between physicians and patients living in the same CTS sites.	Despite geographic variation, there is a strong correlation between physician and

Author	Aim	Setting	Method(s)	Key findings	Comments
	assess how closely patients' satisfaction with their healthcare correlates with physicians' career satisfaction.		(1997-2001). Nationally representative telephone survey of randomly selected participants in 60 CTS communities for a total household population of 179,127 patients and a total physician population of 37,238.	Physician career satisfaction was more strongly correlated with patient overall healthcare satisfaction than any of the other aspects of the healthcare system. Patient trust in the physician was also associated with career satisfaction.	patient satisfaction living in similar geographic locations.
Donahue et al. (2008) (227)	To explore the relationship between nurses' perceptions of empowerment and patient satisfaction.	259 nurses in one U.S. hospital (representing a 58% return rate). Patient sample included 622 survey responses for inpatients (679 responses for ambulatory surgery, and 305 responses for the emergency department).	A descriptive correlational design was used. Instruments used were the Conditions of Work Effectiveness Questionnaire II, which measures nurse empowerment, and the Press Ganey Associates Patient Satisfaction Surveys, which measures patient satisfaction. Patient satisfaction data are routinely obtained by the study hospital on a quarterly basis.	Significant relationships were found between nurses' perceptions of empowerment and access to information, opportunity, support, and resources. A significant positive correlation was found between nurses' perceptions of empowerment and patient satisfaction.	Strategies that may promote nurse empowerment may include improving methods of communication throughout the organisation, for example during the orientation process. Information about opportunities, support, and resources available to them can enhance their productivity, effectiveness, and job satisfaction.
Drach-Zavary (2009) (218)	A study of the moderating effect of caring orientation on the relationship of patient-centred care to nurses' physical and mental health.	Data were collected in 2007 with a random sample of 325 registered nurses working in the Israeli public healthcare sector in in-patient units.	Caring orientation, health and control variables were measured via validated questionnaires. Patient-centred care behaviours were assessed by structured observations.	The mental health of nurses who exhibited high caring orientation combined with high patient-centred care, or that of nurses who exhibited low caring orientation combined with low patient-centred care, was statistically significantly higher in comparison with the mental health of nurses who exhibited incongruent (low/high or high/low) caring orientation and patient-centred care behaviours. For nurses' physical health, the findings revealed that providing patient-centred care was associated with worsened health, and possessing a caring orientation was associated with better health.	The findings support the hypotheses that were derived from person-environment fit and emotional labour only with regard to mental health.

Author	Aim	Setting	Method(s)	Key findings	Comments
Dugan et al. (1996) (208)	To use a range of measures to assess staffing problems, staff stress and patient incidents over a three month period.	Hospital staff on one critical care unit in the U.S.	Measured, over a 3-month period, staffing problems, including turnover rates; nurse incidents, including absenteeism, back injuries, and needle sticks; and patient incidents, including falls and medication errors. The self-reported stress of the nurses caring for these patients was recorded over the same 3-month period.	Data showed that a relatively strong relationship exists between a hospital unit's Stress Continuum Scale (SCS) and the occurrence of patient incidents. The relationship between the SCS and personal incidents and nurse injuries appears weak, as does the relationship between staff turnover and stress. Lagging staff turnover by 1 month resulted in a moderate association with the SCS.	Indicates a relationship exists between team stress levels and the occurrence of patient incidents.
Gardner et al. (2007) (217)	To examine the relationships between staff nurses' perceptions of dialysis work environments, nurses' intentions to leave their current jobs, nurse turnover, patient satisfaction, and patient hospitalization rates.	199 registered nurses in staff nurse roles in 56 dialysis facilities of a national dialysis company. The sample for facility-level analysis consisted of 46 dialysis facilities.	A descriptive correlational design was used. The Practice Environment Scale-Nursing Work Index (PES-NWI) was used to measure nurses' perceptions of the dialysis work environment. Nurses' intention to leave their jobs and facility-level turnover rates were the nurse outcomes examined. Facility-level patient satisfaction and hospitalization rates were the patient outcomes examined.	Overall, nurses rated the work environment somewhat favourably. Nurses who expressed intention to leave their jobs rated the work environment more negatively compared to nurses who intended to stay. Significant correlations were found between nurses' perceptions of the dialysis work environment, nurses' intention to leave their jobs, nurse turnover, and patient hospitalizations.	Study findings suggest that nurses' perceptions of the dialysis work environment are important for nurse and patient outcomes in dialysis settings.
Grol et al. (1985) (200)	To explore general practitioner's views about their work compared to assessments of the quality of patient care provided.	General practitioners in The Netherlands.	The emotional reactions of general practitioners (n=57) to three aspects of work was assessed using questionnaires. The quality of patient care was assessed by means of observations of general practice consultations, assessment of audio taped consulting hour contacts and an analysis of the referral and prescription figures.	Many positive feelings (satisfaction, feeling at ease) correlated with more openness to patients, more attention to psychosocial aspects of the complaints but also with a higher rate of referral to medical specialists. Many negative feelings (frustration, tension, lack of time) correlated with a high prescription rate and with giving little explanation to patients.	To some extent the way that work is experienced by general practitioners correlated with the quality of care for the patients, but what constitutes cause and effect requires further study.

Author	Aim	Setting	Method(s)	Key findings	Comments
Halbesleben et al. (2008a) (354)	To examine the relationship between nurse burnout and patient safety indicators, including both safety perceptions and reporting behaviour.	Nurses from a Veteran's Administration hospital in the U.S.	Nurses completed the Maslach Burnout Inventory and safety outcomes subset of measures from the Agency for Healthcare Research and Quality Patient Safety Culture measure.	After controlling for work-related demographics, multiple regression analysis supported the prediction that burnout was associated with the perception of lower patient safety. Burnout was not associated with event-reporting behaviour but was negatively associated with reporting of mistakes that did not lead to adverse events.	The findings extend previous research on the relationship between burnout and patient outcomes and offer avenues for future research on how nurse motivation resources are invested in light of their stressful work environment.
Halbesleben et al. (2008b) (203)	To explore the relationship between physician burnout and patient satisfaction and the time required to regain normal functioning after hospital discharge.	Physicians and their patients in hospitals in the U.S.	Based upon a survey of 178 matched pairs of patients and physicians. The patients were people who had been hospitalized within the previous year.	After controlling for severity of illness and other demographic factors there was support for the notion that the depersonalization dimension of physician burnout was associated with patient outcomes of lower satisfaction and longer post discharge recovery time.	Suggests that physician burnout has an impact on patient outcomes and those organisations which take proactive steps to reduce burnout by system wide intervention programs will see greater benefits in terms of patient satisfaction and recovery.
Kangas et al. (1999) (215)	To explore differences and relationships among the job satisfaction of registered nurses, patient satisfaction with nursing care, nursing care delivery models, organisational structure, and organisational culture.	Three hospitals representing three different nursing care delivery models, including team nursing, case management, and primary nursing in the U.S.	Correlational descriptive study design. Nurses and patients were selected from the three hospitals. Inclusion criteria for the RNs (n=92) were that they had a minimum of 6 months' nursing experience, had worked in their current hospital for at least 6 months, and were on adult medical-surgical units, inpatient critical care areas, or critical care step-down units. Inclusion criteria for the patients (n=90) were that they were on the same units as the selected RNs and were able to answer the questionnaire.	There were no differences in nurse's job satisfaction or patient satisfaction with nursing care in different organisational structures or where different nursing care delivery models were used. A supportive environment was most important to the job satisfaction of nurses.	Suggests that a supportive environment is a more important factor for nurse job satisfaction than organisational structure or care delivery models.

Author	Aim	Setting	Method(s)	Key findings	Comments
Kazanjan et al. (2005) (214)	To gather, critically appraise and synthesize all relevant primary research on the effect of the nursing environment on patient mortality.	Review study (Canada)	Five electronic bibliographic databases were searched from their beginning through to May/June 2001, and Medline and CINAHL were updated to March 2004, using pre-determined search strategies and inclusion criteria. Studies were included if they met pre-determined criteria, reporting primary data both on a hospital environment and patient mortality.	Nineteen studies found an association between one or more unfavourable attributes and higher mortality. There was considerable variability in attribute and outcome measures, settings and research quality across studies. This precluded statistical pooling of results.	On balance, current evidence indicates that social and environmental attributes of hospital nursing practice have an effect on the outcomes of care. Before optimal practice settings can be designed, further research of greater rigour is needed to provide better evidence of the mechanisms that link the nursing environment to a range of patient outcomes including patient mortality.
Klein et al. (2011) (209)	To examine associations between psychosocial job stress and perceived health care quality among German clinicians in surgery.	All clinicians in surgery working in general hospitals in Germany with a capacity of minimum 100 beds including a general surgical and/or gynaecological ward.	Survey data of 1,311 surgeons from 489 hospitals were analysed. Psychosocial stress at work was measured by the effort-reward imbalance model (ERI) and the demand-control model (job strain). The quality of health care was evaluated by physicians' self-assessed performance, service quality and error frequency. Data were collected in a nationwide standardised mail survey.	Clinicians exposed to job stress have an increased risk of reporting suboptimal quality of care. Magnitude of the association varies depending on the respective job stress model and the indicator of health care quality used.	Findings indicate that theoretical models of psychosocial stress at work can enrich the analysis of effects of working conditions on health care quality. Moreover, results suggest interventions for job related health promotion measures to improve the clinicians' working conditions, their quality of care and patients' health.
Laschinger et al. (2006) (198)	To test a theoretical model of professional nurse work environments linking conditions for professional nursing practice to burnout and, subsequently, patient safety outcomes.	Hospital-based nurses in Canada (n= 8,597)	Survey measures of work life (Practice Environment Scale of the Nursing Work Index), burnout (Maslach Burnout Inventory-Human Service Scale), and report of frequency of adverse patient events.	Nursing leadership played a fundamental role in the quality of work life regarding policy involvement, staffing levels, support for a nursing model of care (versus medical), and nurse/doctor relationships. Staffing adequacy directly affected emotional exhaustion. Use of a nursing model of care had a direct effect on nurses' personal sense of accomplishment in their work.	Suggest that patient safety outcomes are related to the quality of the nursing practice work environment and nursing leadership's role in changing the work environment to decrease nurse burnout.

Author	Aim	Setting	Method(s)	Key findings	Comments
				Both directly affected patient safety	
Leggat et al. (2010) (224)	The aim of this study was to investigate the interactive effects of psychological empowerment and job satisfaction on the relationship between high-performance work systems (HPWS) and nurses' perceptions of the quality of patient care they provide.	Survey data collected in March 2008 from qualified nurses (n=201) in a large regional Australian health service.	Regression analysis with tests of mediation and moderation to analyze survey responses.	Psychological empowerment fully mediated the relationship between HPWS and perceptions of quality of patient care. Job satisfaction moderated the relationship between HPWS and perceptions of quality of patient care.	Suggests that hospital managers should focus on promoting HPWS and ensuring that nurse unit managers have the competencies to empower and to enhance the job satisfaction of their staff.
Leiter et al. (1998) (300)	To examine the relationships of nurse burnout, intention to quit, and meaningfulness of work as assessed on a staff survey with patient satisfaction with nursing care, physician care, information provided and coordination of care, and outcomes of the hospital stay assessed post-discharge.	Sixteen inpatient units from two hospital sites formed the data base and included 605 patients and 711 nurses in Canada.	Staff data were collected as part of an employee survey requested by hospital management to assess the impact of integration of two hospital sites. Measures included the Maslach Burnout Inventory-general survey, meaningfulness of work, and intention to quit. Patient units across the two settings of the hospital complex were included if they had at least three patient responses on a patient satisfaction survey.	Patients' perceptions of the quality of each of the four care dimensions corresponded to the relationships nurses had with their work. Patients on units where nurses found their work meaningful were more satisfied with all aspects of their hospital stay. Patients who stayed on units where nursing staff felt more exhausted or more frequently expressed the intention to quit were less satisfied with the various components of their care. Although nurse cynicism was reflected in lower patient satisfaction with interactions with nursing staff, the correlations between cynicism and other aspects of care fell below statistical significance. No significant correlations were found between nurse professional efficacy and any of the patient satisfaction components measured.	The findings add weight to previous research on the importance of nursing influence on patient satisfaction. This influence is not limited to patient satisfaction with nursing care; rather, it affects patient satisfaction with care provided by doctors, information provided and coordination of care, and outcomes of the hospital stay.

Author	Aim	Setting	Method(s)	Key findings	Comments
McCutcheon et al. (2009) (225)	To examine the relationships between leadership style, span of control, nurses' job satisfaction and patient satisfaction, as well as the moderating effect of span of control on the relationship between leadership style and the two outcomes.	Seven teaching and community hospitals in Canada with a sample of 51 units, 41 nurse managers, 717 nurses and 680 patients.	Nursing staff data was collated to assess leadership style, span of control and job satisfaction. Data analyses included multiple regression and hierarchical linear modeling.	The study findings provided support for the theoretical relationships among leadership style, span of control, nurse job satisfaction and patient satisfaction. The results showed that higher spans of control decreased the positive effects of transformational and transactional leadership styles on job satisfaction and patient satisfaction, and increased the negative effects of management by exception and laissez-faire leadership styles on job satisfaction.	Leadership matters, and certain leadership styles, particularly transformational, are better than others. Span of control also matters: the wider the span, the lower the nurses' job satisfaction and patient satisfaction. However, as spans of control increase in size, no leadership style can overcome the negative effects.
McNeese-Smith (1999) (222)	To examine the relationships between nurse manager motivation and leadership behaviours and patient satisfaction.	Nurse managers working in a large Los Angeles County hospital associated with a major university.	Ex-post facto correlational study. Analyses focus on the following variables: nurse manager motivation for power, achievement and affiliation (N=19), managerial leadership behaviours, staff nurse outcomes of job satisfaction, productivity and organisational commitment (N=221) and patient satisfaction (N=299).	Managerial motivation for power is negatively correlated with manager use of leadership behaviours and staff nurse job satisfaction but positively correlated with patient satisfaction. Managerial motivation for achievement is positively correlated with use of leadership behaviours as well as nurse job satisfaction, productivity and organisational commitment, and generally to patient satisfaction. Managerial motivation for affiliation reveals few significant positive or negative relationships with other variables.	Both power and achievement motivation of the manager influence staff and patient outcomes in health care.

Author	Aim	Setting	Method(s)	Key findings	Comments
Parker et al. (1995) (191)	To examine how nurse job stress and work support predict the experience of burnout and how burnout is related to absenteeism and job performance.	Registered nurses in a large city hospital in the U.S.	Sample of 73 registered nurses (aged 23–65 yrs).	Levels of work support and job stress were both significant predictors of burnout. Higher burnout levels were significantly associated with poorer self-rated and supervisor-rated job performance, more sick leave, and more reported absences for mental health reasons. Further analyses suggest that level of burnout served as a mediator of the relationships between social support and self-rated job performance, absences for mental health reasons, and intentions to quit.	Suggests that burnout not only may negatively impact healthcare providers, but also may influence objective absenteeism and supervisor perceptions of employee performance.
Poghosyan et al. (2010) (196)	To explore the relationship between nurse burnout and nurse ratings of quality of care.	The study used data from 53,846 nurses from six countries. Data were collected from 1998 to 2005.	Secondary analysis using data from the International Hospital Outcomes Study. The Maslach Burnout Inventory and a single-item reflecting nurse-rated quality of care were used in multiple logistic regression modeling to investigate the association between nurse burnout and nurse-rated quality of care.	Across countries, higher levels of burnout were associated with lower ratings of the quality of care independent of nurses' ratings of practice environments.	Suggest that reducing nurse burnout may be an effective strategy for improving nurse-rated quality of care in hospitals.

Author	Aim	Setting	Method(s)	Key findings	Comments
Robertson et al. (1995) (190)	To identify the main correlates of morale/job satisfaction among staff assigned to the care of elderly people with dementia living in psychiatric hospitals; and to measure the effect of variations in job satisfaction upon the quality of care provided to patients.	Nursing staff working on psychogeriatric units in NHS hospitals in Scotland.	The investigation was carried out in two phases. In Phase I, a comprehensive survey was undertaken of all nursing staff working in a stratified sample of 121 wards in all of the 39 NHS hospitals in Scotland containing a psychogeriatric unit, to assess the level and correlates of work satisfaction within those wards. The main survey instrument was a self-completion questionnaire comprising some 150 questions. In Phase II, an in-depth observational study was carried out in two 'high-satisfaction' (HS) and two 'low-satisfaction' (LS) hospitals. In all four hospitals two wards were selected for intensive study over a period of 4–5 months each. Quality of care was studied through standardized recording of staff's feeding, toileting and bathing of a stratified sample of patients.	The findings point to a very strong relationship between job satisfaction and quality of patient care. Staff and patients in high-satisfaction (HS) wards proved more likely to initiate a conversation or other interaction. HS staff also offered patients more choice, independence, personal attention, supervision, information and privacy. HS staff were more likely to converse with patients during feeding, toileting and bathing. Toileting and bathing appeared especially sensitive to these effects. Despite these differences, HS staff took no longer to feed, toilet or bathe their patients.	Relationships are suggested to be mainly attributable to management practices, particularly at ward level, which influence both job satisfaction and quality of patient care.
Raup (2008) (355)	To determine what types of leadership styles were used by emergency department nurse managers in academic health centre hospitals and examine their influence on staff nurse turnover and patient satisfaction.	Surveys (15 managers and 30 staff nurses) representing 15 out of 98 possible U.S. academic health centres.	Emergency Department (ED) nurse managers were asked to complete the Multifactor Leadership Questionnaire and a 10-item researcher defined nurse manager role and practice demographics survey.	A trend of lower staff nurse turnover with ED manager transformational leadership style compared to non-transformational leadership styles was identified. The type of leadership style did not appear to have an effect on patient satisfaction.	Leadership style may have no direct effect on patient satisfaction, however leadership style does have an impact on staff retention.
Schanafelt et al. (2002) (199)	To determine the prevalence of burnout in medical residents and explore its relationship to self-reported patient care	University-based residency program in Seattle, Washington, U.S.	Cross-sectional study using an anonymous postal survey.	Of 115 (76%) responding residents, 87 (76%) met the criteria for burnout. Burned-out residents were significantly more likely to self-report providing at least one type of suboptimal patient care at least monthly (53% vs. 21%).	Burnout was common among resident physicians and was associated with self-reported suboptimal patient care practices.

Author	Aim	Setting	Method(s)	Key findings	Comments
	practices.			Only a high score for depersonalization was associated with self-reported suboptimal patient care practices (in a dose-response relationship).	
Shirom et al. (2006) (204)	To test specific expectations considering the extent to which physicians' burnout and each of its facets - physical fatigue, emotional exhaustion, and cognitive weariness - predicted the quality of care that the physicians provided to their patients.	Survey data from physicians in Israel.	Physicians (n=890) representing six medical specialties.	Including global burnout as well as its three first-order facets of physical fatigue, cognitive weariness, and emotional exhaustion improved the fit between the structural model and the data relative to an alternative model that included only global burnout. Workload (number of work hours) indirectly predicted quality of care through perceived overload. Additionally, the paths from the first order factors of emotional exhaustion, physical fatigue, and cognitive weariness predicted quality of care negatively, positively, and non-significantly, respectively.	Perceived overload, long known to be the most potent predictor of burnout (Schaufeli & Enzmann, 1998), should be considered as a prime culprit in that it probably leads to both elevated levels of burnout and reduced levels of quality of care.
Teng et al. (2009a) (207)	To examine the influence of the emotional stability of nurses on patient safety.	263 nurses working in two Taiwanese medical centres.	A cross-sectional design was adopted.	Hierarchical regression analysis indicated that emotional stability predicted patient safety. The addition of emotional stability as a predictor of patient safety increased the associated explained variance.	It is important for to managers create an organisational climate that promotes the emotional stability of nurses. This could help to improve global patient safety by reducing the frequency of adverse events.
Teng et al. (2009b) (201)	To examine how professional commitment influences patient safety and patient-perceived care quality	348 pairs of nurses and inpatients at two medical centers in Taiwan during the period from August 2007 to January 2008, yielding 284 pairs of	Cross-sectional design with questionnaires. Frequencies of six adverse patient events were used to measure patient safety; and the Service Quality Scale was used to measure patient-perceived care quality. Four items of the Professional	Professional commitment positively influenced overall patient safety and overall patient-perceived care quality. Professional commitment positively influenced all patient safety indicators, except frequency of nosocomial infections, which was not significant.	Professional commitment may enhance patient safety and patient-perceived care quality.

Author	Aim	Setting	Method(s)	Key findings	Comments
		completed questionnaires.	Commitment Questionnaire were used to measure professional commitment.	Professional commitment also positively influenced care quality in terms of responsiveness and empathy.	
Teng et al. (2010a) (206)	To examine how time pressure among nurses influences patient-perceived care quality	229 nurse-patient sets drawn from a medical centre in northern Taiwan. Each set comprised one nurse and three patients.	A cross-sectional design and survey method	The study results demonstrate that time pressure among nurses reduces patient-perceived reliability/accountability, responsiveness and assurance. The test results, however, did not indicate a significant negative association between time pressure and patient-perceived empathy and tangibles.	Time pressure among nurses may reduce patient perception of care quality in terms of reliability/accountability, responsiveness and assurance.
Teng et al. (2010b) (356)	To investigate how time pressure and the interaction of time pressure and nursing burnout affect patient safety.	458 nurses in 90 units of two medical centres in northern Taiwan.	Cross-sectional survey. Nursing burnout was measured by the Maslach Burnout Inventory-Human Service Scale. Patient safety was inversely measured by six items on frequency of adverse events. Time pressure was measured by five items	While the results of regression analyses suggest that time pressure did not significantly affect patient safety, time pressure and burnout had an interactive effect on patient safety. Specifically, for nurses with high burnout (n=223), time pressure was negatively related to patient safety.	Time pressure adversely affected patient safety for nurses with a high level of burnout, but not for nurses with a low level of burnout.
Tzeng et al. (2002) (216)	To investigate the relationship among staff nurses' assessment of organisational culture, job satisfaction, and inpatient satisfaction.	Staff nurses and inpatients from 17 inpatient units (13 adult surgical/medical, 2 psychiatric, 2 gynaecological/obstetric) in Taiwan.	Only those units with at least four staff nurses' and patients' responses were included. Descriptive data and Pearson correlation coefficients were calculated among included variables. A conceptual path model was tested using a secondary data analysis research design. Regression analyses were used to test the direct linkages in the conceptual model.	Strength of organisational culture positively predicted job satisfaction. Job satisfaction predicted inpatient satisfaction significantly and positively. Inpatient satisfaction predicted general inpatient satisfaction well and positively.	Substantiates previous research on positive influence of organisational culture on job satisfaction and inpatient satisfaction.

Author	Aim	Setting	Method(s)	Key findings	Comments
Vahey et al. (2004) (194)	Examines the effect of the nurse work environment on nurse burnout, and the effects of the nurse work environment and nurse burnout on patients' satisfaction with their nursing care.	Nurses (n = 820) and patients (n = 621) from 40 units in 20 urban hospitals across the U.S.	Cross-sectional surveys. Nurse surveys included measures of nurses' practice environments derived from the revised Nursing Work Index (NWI-R) and nurse outcomes measured by the Maslach Burnout Inventory (MBI) and intentions to leave. Patients were interviewed about their satisfaction with nursing care using the La Monica-Oberst Patient Satisfaction Scale (LOPSS).	Patients cared for on units that nurses characterized as having adequate staff, good administrative support for nursing care, and good relations between doctors and nurses were more than twice likely as other patients to report high satisfaction with their care, and their nurses reported significantly lower burnout. The overall level of nurse burnout on hospital units also affected patient satisfaction.	Improvements in nurses' work environments in hospitals have the potential to simultaneously reduce nurses' high levels of job burnout and risk of turnover and increase patients' satisfaction with their care.
Van den Hombergh et al. (2009) (197)	To explore whether high workload and job stress are associated with lower performance in general practices in the Netherlands.	239 general practices in the Netherlands.	Secondary data analyses. Data were collected by a practice visitor, a trained non-physician observer using questionnaires for patient, doctor and staff data.	Workload and job stress are associated with practice performance. Working more hours as a GP was associated with more positive patient experiences of accessibility and availability (b = 0.16). After list size adjustment, practices with more GP-time per patient scored higher on GP care (b = 0.45). When GPs provided more than 20 hours per week per 1000 patients, patients scored over 80% on the Europep questionnaire for quality of GP care. High GP job stress was associated with lower accessibility and availability (b = 0.21) and insufficient practice management (b = 0.25). Higher GP commitment and more satisfaction with the job was associated with more prevention and disease management (b = 0.35).	Providing more time in the practice, and more time per patient and experiencing less job stress are all associated with perceptions by patients of better care and better practice performance. Workload and job stress should be assessed by using list size adjusted data in order to realise better quality of care. Organisational development using this kind of data feedback could benefit both patients and GP.
Weisman et al. (1985) (205)	To examine the relationship between the aggregate job satisfaction level of family planning nurses and outcomes for teenage clients.	Nursing staff in 77 family planning clinics in the U.S.	The study used two client outcomes: the aggregate satisfaction level of teenage clients with contraceptive services obtained in the clinic, and the subsequent rate of client compliance with contraceptive prescriptions.	Job satisfaction level of nursing staff is the strongest determinant of the aggregate satisfaction level of clients. Client satisfaction level, in turn, predicts the rate of clients' subsequent contraceptive compliance. Staff satisfaction has a noteworthy indirect effect on compliance through client satisfaction.	Job satisfaction was strongly related to client satisfaction.

Author	Aim	Setting	Method(s)	Key findings	Comments
				Compliance, however, appears to be more susceptible to variations in clinic structure than to variations in staff satisfaction levels.	
Williams et al. (2007) (202)	To identify which cultural conditions affect physician stress, dissatisfaction, and burnout, and to determine whether stressed, dissatisfied, and burned out physicians deliver poorer quality care.	426 primary care physicians participating in 'Minimizing Error, Maximizing Outcome' (MEMO) study.	A conceptual model incorporating the research questions was analyzed via structural equation modeling.	Culture, overall, played a lesser role than hypothesized. A cultural emphasis on quality played a key role in both quality outcomes. Stressed, burned out, and dissatisfied physicians do report a greater likelihood of making errors and more frequent instance of suboptimal patient care.	Creating and sustaining a cultural emphasis on quality is not an easy task, but is worthwhile for patients, physicians, and health care organisations. Further, having clinicians who are satisfied and not burned out or stressed contributes substantially to the delivery of quality care.
Yang et al. (2005) (223)	To examine staff nurses' morale and its effect on patient satisfaction.	332 nurses and 265 inpatients in 21 medical-surgical units of a medical centre in Taiwan.	Data were collected with structured questionnaires. All registered nurses (RN) among 21 sample units were recruited and administered with Litwin and Stringer's (1968) Work Morale Scale. A convenience sampling was implemented to select those patients who had been admitted for at least 3 days and were ready to be discharged. Yang's (1997) Nursing-Sensitive Patient Satisfaction Scale was used to measure patient outcomes.	Job position and pay had a significant effect on nurses' work morale. Nurses' work morale may not necessarily be an impact factor on patient satisfaction, but it accounts for 66.7 percent of the discriminate power to predict nursing-sensitive patient satisfaction.	Nursing leaders should put effort into improving nurses' involvement and identification with their organisations, both of which are significant factors associated with nursing unit morale.

Appendix 7 Empirical studies of organisational interventions to improve staff wellbeing and patient experience in the NHS context

Author	Aim	Setting	Method(s)	Key findings	Comments
Boaden (2008) (240)	To examine employee perspectives of how Human Resource Management influences their performance.	In-depth studies of six NHS hospitals.	Six in-depth case studies of high performing NHS hospitals (n=170 interviews). Data collected included contextual and background data; questionnaire asked employee views on how HRM influences performance.	Organisational strategies for HRM varied greatly, with no evidence of any one 'best' way of organising HRM. HRM content was similar in each organisation although the priority given to different practices varied depending on organisational strategy. Perception of HRM showed practices grouped to (a) those that support professional development; (b) employee contribution; and (c) the 'employee deal'. Explicit and tacit expectations of individuals at work: having expectations met led to effective patient care. Individual performance was concerned with how an individual does her work/his work, which then lead to outcomes for patients. Organisational performance was perceived as being assessed using 'targets' that were seen by some to be in conflict with patient care.	Suggests tensions between individual and organisational performance in terms of a desire to provide care for patients.
Bolton & Way (2007) (111)	Examines the role of various management functions and strategic potential of HRM in the NHS.	One large hospital in England.	One-to-one conversational interviews (60 to 90 minutes) with senior medical professionals and HR managers (n=6). Interviews were undertaken within an analysis of the changing roles of HR in NHS hospital since 1998.	Examines the NHS hospital service as an example of a 'negotiated order' (Strauss 2001) of competing clinical and managerial values and interests. Proposes the role of HR is to mediate between different values and professional and organisational interests; to create vocabularies that carry shared meanings and values for different groups in the hospital.	The care and management priorities of nurses are not addressed here but it provides a useful conceptual starting point.

Author	Aim	Setting	Method(s)	Key findings	Comments
				Staff wellbeing – as HR issue is typically comprised of Occupational Health issues and retention. NHS initiatives such as Improving Working Lives have had a significant influence.	
Goodrich & Cornwell (2008) (87)	To examine perceptions and experiences of care and care giving from the perspectives of staff and patients.	NHS patients and NHS staff of one London hospital.	UK and US literature review. Former NHS patients (geographically dispersed). NHS staff (one London teaching hospital).	Highlights the tension between intended moral and ethical purpose of care and the day-to-day difficulties of sustaining this care. Argues for improvements in care ‘not simply by individual acts and commitment’ but also by organisational (institutional, regional and national interventions). Discusses staff motivation to care for patients with humanity and decency Suggests that the quality of staff relationships with patients positively influences job satisfaction. Suggest staff mourn the loss of personal relationships, face-to-face contact, corridor conversations in the context of increased workloads.	Raises questions about how the scale of healthcare undermines staff/patient relations: depersonalising; reduced patient contact time and length of hospital staff in direct contact with patients.
Hyde (2006) (239)	To explore how Human Resource Management can help NHS organisations achieve their goals to improve patient care.	Secondary analysis of 97 research studies (all sectors and international).	A review of the theory of HRM and a semi-systematic review of the empirical literature on the link between HRM and staff performance were carried out.	Studies generally did not make explicit the theoretical perspective used. Many used individual questionnaire surveys. Majority of papers (>80%) used methods that enabled them to show that HRM is associated with performance, but couldn't provide evidence that HRM causes changes in performance. The three HRM elements that demonstrated the largest number of positive associations with performance were: training/development; pay incentives; and involvement/voice. Some studies reported that trust, commitment, skill, attitudes and motivation	Suggests important factors in staff performance include opportunities for development; pay incentives; and involvement in organisational decision making.

Author	Aim	Setting	Method(s)	Key findings	Comments
Purcell (2004) (357)	Assesses impact of people management on organisational performance.	5 large companies (production, financial services, retail, one hospital trust selected either for good national reputation or because attempting HR reforms.	A study of policy implementation from the perspective of employees. Examines which HR policies are most significant to levels of organisational commitment and job satisfaction for different employee groups. Survey of employees (609 interviews with 428 employees - met twice over successive years).	<p>were important.</p> <p>Proposes that high levels of job satisfaction and high levels of organisational commitment lead to high levels of 'organisation citizenship behaviour' that enhances performance.</p> <p>Available key performance measures were - staff turnover, retention, absence, accidents, employee satisfaction measures, and business related operational measures.</p> <p>Staff reported factors were -team work, involvement, culture and leadership</p> <p>Line managers were crucial mediators in employee's experiences of HR policy and practice; managerial behaviour (leadership style; ability to bring policies to life) accounted for performance variations in organisations; for employees' satisfaction with managerial behaviour and for their overall organisational commitment.</p> <p>Three types of employees (professional, front-line managerial, workers) identified as requiring a different policy mix to support their organisational commitment.</p> <p>Nurses are specifically identified as requiring HR policies that support good work communications (good leadership); recognition and good rewards.</p>	Organisational factors do not feature prominently in analysis. Nurses, in contrast to other hospital staff, are identified as having specific HR requirements.

Appendix 8 Phase I: Focus group topic guide

- Thinking back to a recent experience you have had with the NHS how would you describe how staff behaved towards you? Were you generally happy with the way staff spoke and acted towards you? Probe -doctors, nurse and non medical staff? Would show a difference?
- Did some staff behave differently towards you than others? in what ways? why do you think this was?
- Do you feel you were treated differently than other patients on your ward and if so how? Were some staff better at spending time with you and explaining things than others? Probe re staff type?
- How would you describe your relationship with various staff (did you feel they treated you with respect; did you trust them; were they approachable, kind, caring?) If not – did you observe better / different relationships with other patients
- Did you have any problems or difficult/stressful encounters with any staff? If so, what do you think caused this?
- What did it feel like when you staff were talking to you? (friendly, open, relaxed / rude, disrespectful and did this affect other patients?)
- Did it feel different when doctors were speaking to you compared with nurses or other staff? In what way(s)?
- Did staff appeared stressed, tired or overworked to you? Or did they seem generally happy in their work? Were you told by staff why they are tired (effect of a drunken night out / having 2 hours sleep before starting their shift) if so, do you think this effected the way they behaved towards you?
- Is the way staff behave towards you important in terms of your overall experience? or doesn't it matter as long as you are seen and treated?
- If it is important, can you describe any really positive memories you have of how staff behaved towards you (any things they did 'over and above the call of duty'!) or alternatively any bad memories (where you felt really let down)?
- What do you think led staff to act in either these positive or negative ways towards you?

Appendix 9 Phase I: Senior manager interview schedule

How long have you worked for [ORGANISATION], and in what role? How would you describe your responsibilities (direct/indirect) for either staff wellbeing and/or patient experience?

What do you understand by the phrase 'staff wellbeing'? What aspects of wellbeing do you think are most important (a) to staff themselves, and (b) to patients?

Can you briefly tell us about the important committees/ working groups in [ORGANISATION] that explicitly include staff wellbeing and/or patient experience within their remit?

In your view, what are the most important policies and strategies that [ORGANISATION] has for enhancing staff wellbeing? How is [ORGANISATION] currently trying to bring about improvements in staff wellbeing?

In your view, what are the most important policies and strategies that [ORGANISATION] has for enhancing patient experience? How is [ORGANISATION] currently trying to bring about improvements in patient experience?

What is your view of the level of staff wellbeing in [ORGANISATION] at the moment? *[could ask to compare to other organisations they have worked in]* What aspects of staff wellbeing are highest on the organisation's agenda right now? Any particular issues? Any particular staff groups?

What is your view of the quality of 'patient experience' in [ORGANISATION] at the moment? *[could ask to compare to other organisations they have worked in]* What specific aspects of patient experience are highest on the organisation's agenda right now?

Do you think staff wellbeing and patient experience are linked or associated? In what ways? *[what staff attitudes and behaviours might impact on patient experience? How might staff wellbeing shape these attitudes and behaviours? How might patient experience impact on staff wellbeing?]* Any evidence for/examples of this in [ORGANISATION]?

How do you measure staff wellbeing in [ORGANISATION]? *[tools, ongoing monitoring, feedback etc n.b. routine data]*

How do you measure patient experience in [ORGANISATION]? *[tools, ongoing monitoring, PROMS, feedback etc n.b. routine data]*

In the next phase of this research we will be looking in-depth at staff wellbeing and patient experience in two clinical services. Which two services

would you suggest we study? *[Are there particular services in [ORGANISATION] where you think staff wellbeing is relatively high? Any where staff wellbeing is relatively low? Are there particular services in [ORGANISATION] where you think patient experience is relatively high? Any where patient experience is relatively low?]*

Is there anything you would like to add?

Appendix 10 Phase II: Staff wellbeing

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Patient Experience of Care and Staff Well-being

Staff Survey

What is this survey and why are we asking you to complete it?

This is an independent survey of your experience of working at your Trust. The overall aim is to gather information that will help to improve the working lives of NHS staff and to help them provide better care for patients. The researchers will be able to use the results of the survey to understand staff experiences and any links to patient experience.

Please complete the survey for your current job, or the job you do most of the time.

The survey will take approximately 20 minutes to complete.

Who will see my answers?

The survey is being conducted by Dr Jill Maben and the research team at King's College, London (University of London). The survey findings will be analysed by Professor Riccardo Peccei, King's College, London, and the results will be presented in a summary report in which no individual, or their responses, can be identified.

It will be fed back anonymously to your organisation to allow them to improve local working conditions and to make progress in improving staff wellbeing and patient experience.

Please return this questionnaire, in the envelope provided, to:

Dr Jill Maben
National Nursing Research Unit
King's College London
Freepost Lon1124
London SE1 8YY

If you have any queries about this questionnaire please contact the National Nursing Research Unit at King's College, London on 020 7848 3057 or nnru@kcl.ac.uk

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Please read each question carefully, but give your immediate response by circling the number or ticking the box which best matches your personal view.

SECTION I: SUPPORT AND RESOURCES TO DO MY JOB

A	To what extent do you agree or disagree with the following?	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
1	My immediate manager is very committed to improving the quality of care provided to patients in our area	1	2	3	4	5
2	This Trust fails to appreciate any extra effort from me	1	2	3	4	5
3	My job requires that I work very hard	1	2	3	4	5
4	Most of my co-workers are very committed to improving the quality of care provided to patients in our area	1	2	3	4	5
5	I can rely on my co-workers when things get difficult on the job	1	2	3	4	5
6	I have adequate materials, supplies and equipment to do my work	1	2	3	4	5
7	I know exactly what is expected of me in my job	1	2	3	4	5
8	This Trust is committed to helping staff balance their work and home life	1	2	3	4	5
9	My immediate manager sets a personal example of high quality patient care in her/his daily job	1	2	3	4	5
10	This Trust values my contribution to its well-being	1	2	3	4	5
11	My co-workers are willing to listen to my job related problems	1	2	3	4	5
12	I do not have time to carry out all my work	1	2	3	4	5
13	Most of my co-workers go out of their way for patients	1	2	3	4	5
14	There are enough staff at this Trust for me to do my job properly	1	2	3	4	5
15	I always know what my work responsibilities are	1	2	3	4	5
16	My immediate manager helps me find a good work-life balance	1	2	3	4	5
17	This Trust would ignore any complaint from me	1	2	3	4	5
18	My immediate manager recognises and appreciates high quality patient care	1	2	3	4	5
19	My co-workers are helpful to me in getting my job done	1	2	3	4	5
20	I often have too much work to do on my job	1	2	3	4	5
21	Most of my co-workers put a lot of effort into trying to provide high quality care to patients	1	2	3	4	5

To what extent do you agree or disagree with the following?		strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	
22	Rules and regulations here often get in the way of doing the job properly	1	2	3	4	5	
23	I have a clear idea of what has to be done in my job	1	2	3	4	5	
24	I can approach my immediate manager to talk openly about flexible working	1	2	3	4	5	
25	This Trust really cares for my well-being	1	2	3	4	5	
26	My job is emotionally demanding	1	2	3	4	5	
27	Targets here often get in the way of doing the job properly	1	2	3	4	5	
28	I have clear, planned goals and objectives for my job	1	2	3	4	5	
29	The Trust shows very little concern for me	1	2	3	4	5	
30	Even if I did the best job possible, the organisation would fail to notice	1	2	3	4	5	
31	My work requires my undivided attention	1	2	3	4	5	
32	The Trust cares for my general satisfaction at work	1	2	3	4	5	
33	The Trust takes pride in my accomplishments at work	1	2	3	4	5	
B Problems at work							
1	During the last 12 months have you been injured or felt unwell as a result of the following problems at work?						
	a. Moving and handling				Yes	No	
	b. Needlestick and sharps injuries				Yes	No	
	c. Slips, trips or falls				Yes	No	
	d. Exposure to dangerous substances				Yes	No	
	e. Work-related stress				Yes	No	
2	Support for staff						
	a. Do you have access to counselling services at your Trust?				Yes	No	Don't know
	b. Do you have access to occupational health services at your Trust?				Yes	No	Don't know
3	In the last 12 months, have you personally experienced physical violence at work from any of the following?						
	a. Patients/Service users				Yes	No	
	b. Relatives of patients/Service users				Yes	No	
	c. Other members of the public				Yes	No	
	d. Manager/Team leader				Yes	No	
	e. Other colleagues				Yes	No	

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4	In the last 12 months, have you personally experienced harassment, bullying or abuse at work from any of the following?		
	a. Patients/Service users	Yes	No
	b. Relatives of patients/Service users	Yes	No
	c. Other members of the public	Yes	No
	d. Manager/Team leader	Yes	No
	e. Other colleagues	Yes	No

C	The following questions are about your immediate manager. He/She:	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
1	Can be counted on to help me with a difficult task at work	1	2	3	4	5
2	Gives me clear feedback on my work	1	2	3	4	5
3	Asks for my opinion before making decisions that affect my work	1	2	3	4	5
4	Genuinely cares for my well-being	1	2	3	4	5
5	Helps me when my workload is not manageable	1	2	3	4	5

D	The following question is about your working hours.	
1	How many hours, including any paid or unpaid overtime, do you usually work in your job each week?	Total hours per week

SECTION II: HOW I FEEL ABOUT MY JOB

E	To what extent do you agree or disagree with the following?	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
1	I would fail in my duty if I neglected my patients	1	2	3	4	5
2	I get a lot of satisfaction from dealing with patients	1	2	3	4	5
3	No matter what the odds, if I believe in something, I will make it happen	1	2	3	4	5
4	I find the work that I do full of meaning and purpose	1	2	3	4	5
5	I am confident in my ability to do my job	1	2	3	4	5
6	The sadness of a patient easily rubs off on me	1	2	3	4	5
7	I often feel under a lot of pressure at work	1	2	3	4	5
8	I feel morally responsible for the welfare of my patients	1	2	3	4	5
9	Helping patients is the most rewarding part of my job	1	2	3	4	5

	To what extent do you agree or disagree with the following?	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
10	I love being a champion for my ideas, even against others' opposition	1	2	3	4	5
11	I am enthusiastic about my job	1	2	3	4	5
12	I have mastered the skills necessary for my job	1	2	3	4	5
13	I worry a lot about my work outside working hours	1	2	3	4	5
14	Staff should always put the interests of patients above their own interests	1	2	3	4	5
15	I get a lot of positive feedback from patients	1	2	3	4	5
16	I am excellent at identifying opportunities and acting on them	1	2	3	4	5
17	My job inspires me	1	2	3	4	5
18	I find dealing with patients emotionally exhausting	1	2	3	4	5
19	I am proud of the work that I do	1	2	3	4	5
20	I am confident in my ability to deal with most problems in my job	1	2	3	4	5
21	I don't get overly involved with patients' problems	1	2	3	4	5
22	I am not affected easily by the strong emotions of patients around me	1	2	3	4	5
23	My job is stressful	1	2	3	4	5
24	I feel my job is secure in this workplace/Trust	1	2	3	4	5

SECTION III: CARING FOR PATIENTS

F	To what extent do you agree or disagree with the following?	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
1	I have the necessary skills to deal effectively with all patient needs	1	2	3	4	5
2	I am always ready to go the 'extra mile' for patients	1	2	3	4	5
3	I am not always able to spend as much time as I would like with patients	1	2	3	4	5
4	I have specific ideas about how to improve patient care in our area	1	2	3	4	5
5	I often do more for my patients than is formally required of me	1	2	3	4	5

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	To what extent do you agree or disagree with the following?	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
6	I am satisfied with the quality of care I give to patients	1	2	3	4	5
7	I am not all that good at dealing with difficult patients	1	2	3	4	5
8	I am more committed than most to providing high quality care to patients	1	2	3	4	5
9	I don't always have the authority to look after patients the way I think best	1	2	3	4	5
10	I give a lot of thought to the needs of my patients	1	2	3	4	5
11	I feel that my role makes a difference to patients	1	2	3	4	5
12	I am better than most at responding to patient needs and problems	1	2	3	4	5
13	Some days I'm not all that motivated to go out of my way for patients	1	2	3	4	5
14	I have plenty of scope in my job to look after patients the way I think is best	1	2	3	4	5
15	I often make suggestions about how to improve patient care in our area	1	2	3	4	5
16	No matter how I feel, I always put myself out for every patient I deal with	1	2	3	4	5
17	I make it my business to think of ways of improving patient care in our area	1	2	3	4	5
18	I still have quite a lot to learn about how best to deal with and care for patients	1	2	3	4	5
19	I put a lot of effort into my job to try to provide effective care to patients	1	2	3	4	5
20	I am able to deliver the patient care I aspire to	1	2	3	4	5
21	I often go out of my way to help patients	1	2	3	4	5
22	I am always working to improve the quality of care I give to patients	1	2	3	4	5

G		How would you rate each of the following in your Trust?	Very poor	Poor	neither good nor poor	Good	Very good
1	The job knowledge and skills of employees to deliver high quality care to patients		1	2	3	4	5
2	Efforts to measure and track the quality of care provided to patients		1	2	3	4	5
3	The recognition and rewards staff receive for the delivery of high quality care to patients		1	2	3	4	5
4	The overall quality of care provided to patients		1	2	3	4	5
5	The leadership shown by management in supporting high quality patient care		1	2	3	4	5
6	The tools, technology, and other resources provided to staff to deliver high quality patient care		1	2	3	4	5

H		Overall, how would you rate your own effectiveness on each of the following?	Not Very effective	About average					Very effective		
1	Comforting patients in distress		1	2	3	4	5	6	7	8	9
2	Providing feedback to patients about their progress		1	2	3	4	5	6	7	8	9
3	Responding to patients needs and preferences		1	2	3	4	5	6	7	8	9
4	Communicating with patients		1	2	3	4	5	6	7	8	9
5	Helping co-ordinate care and support from other services		1	2	3	4	5	6	7	8	9
6	Providing emotional support to patients		1	2	3	4	5	6	7	8	9
7	Looking after the physical comfort of patients		1	2	3	4	5	6	7	8	9
8	Helping patients to manage and control pain		1	2	3	4	5	6	7	8	9
9	Arranging transfer of patients to other services		1	2	3	4	5	6	7	8	9
10	Winning the trust and cooperation of patients' family and friends		1	2	3	4	5	6	7	8	9
11	Relieving patients' fears and anxieties		1	2	3	4	5	6	7	8	9
12	Communicating with patients' family and friends		1	2	3	4	5	6	7	8	9

SECTION IV: YOUR WELLBEING

I		Never	Occasionally	Some of the time	Most of the time	All of the time
Thinking of the past few weeks, how much of the time has your job made you feel each of the following?						
1	Tense	1	2	3	4	5
2	Miserable	1	2	3	4	5
3	Depressed	1	2	3	4	5
4	Optimistic	1	2	3	4	5
5	Calm	1	2	3	4	5
6	Relaxed	1	2	3	4	5
7	Worried	1	2	3	4	5
8	Enthusiastic	1	2	3	4	5
9	Uneasy	1	2	3	4	5
10	Contented	1	2	3	4	5
11	Gloomy	1	2	3	4	5
12	Cheerful	1	2	3	4	5

J		Not at all	Rarely	Sometimes	Often	Very often
Consider the extent to which you feel the following						
1	I feel emotionally drained from my work	1	2	3	4	5
2	I feel used up at the end of the working day	1	2	3	4	5
3	I feel burned out from my work	1	2	3	4	5
4	I feel I'm working too hard on my job	1	2	3	4	5
5	I dread getting up in the morning and having to face another day on the job	1	2	3	4	5
6	My work really puts a lot of strain on me	1	2	3	4	5
7	My work puts too much stress on me	1	2	3	4	5
8	I feel frustrated in my job	1	2	3	4	5
9	To get through my workday, I feel I have to become mechanical or robot-like	1	2	3	4	5
10	I worry that this job is hardening me emotionally	1	2	3	4	5
11	I have to fake how I really feel at work	1	2	3	4	5

K	In general, to what extent can you:	Not at all	To some extent	To a considerable extent	To a great extent	To a very great extent
1	Determine the methods and procedures you use in your work	1	2	3	4	5
2	Choose what work you will carry out	1	2	3	4	5
3	Decide on your own how you go about doing your work	1	2	3	4	5
4	Determine the pace at which you work	1	2	3	4	5

L	Job satisfaction	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
1	Overall, how satisfied are you with your job?	1	2	3	4	5

M	Please consider the last four weeks and answer the following questions by selecting and circling one of the four answer options [ⓐ]. Have you:				
1	Been able to concentrate on what you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	Felt you were playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4	Felt capable of making decisions about things?	More so than usual	Same as usual	Less than usual	Much less than usual
5	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6	Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less than usual	Much less than usual
8	Been able to face up to your problems?	More so than usual	Same as usual	Less than usual	Much less than usual
9	Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10	Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12	Been feeling reasonably happy, all things considered	More so than usual	About the same as usual	Less than usual	Much less than usual

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N Overall, please rate how you consider your general physical health to be at the moment						
1		Very good	Fairly good	Moderate	Fairly poor	Very poor
O During the past four weeks, how much difficulty did you have doing your daily work, because of your physical health?						
1		None at all	A little bit	Some	Quite a lot	Could not do daily work

SECTION V: ABOUT YOU

P	
1	Which Ward(s) do you mostly work on?
2	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
3	Age <input type="checkbox"/> 16-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> 31-40 <input type="checkbox"/> 41-50 <input type="checkbox"/> 51-65 <input type="checkbox"/> 66+

Q What is your ethnic origin?	
	White (British/Irish/Any other White background) <input type="checkbox"/>
	Mixed (White and Black Caribbean/White and Black African/White and Asian/Any other mixed background) <input type="checkbox"/>
	Asian/Asian British(Indian/Pakistani/Bangladeshi/Any other Asian background) <input type="checkbox"/>
	Black/Black British (Caribbean/African/Any other Black background) <input type="checkbox"/>
	Chinese and other ethnic background (Chinese/Other ethnic background) <input type="checkbox"/>

R How many years have you worked for the Trust?					
If your Trust has merged with another or change its name, please include in your answer all the time you have worked with this Trust and its predecessors					
1	Less than one year	<input type="checkbox"/>	2	1-2 years	<input type="checkbox"/>
3	3-5 years	<input type="checkbox"/>	4	6-10 years	<input type="checkbox"/>
5	11-15 years	<input type="checkbox"/>	6	More than 15 years	<input type="checkbox"/>

S Your job			
Do you manage staff within the Trust?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have face-to-face contact with patients/service users as part of your job?	<input type="checkbox"/> Yes frequently	<input type="checkbox"/> Yes occasionally	<input type="checkbox"/> No

T And finally, some questions about your team			
1	Do you work in a team? If YES, please answer the following few questions about the main team you work in:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Does your team have clear objectives?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	Do you have to work closely with other team members to achieve the team's objectives?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Does the team meet regularly and discuss its effectiveness and how it could be improved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	How many core members are there in your team?	<input type="checkbox"/> 2-5	<input type="checkbox"/> 6-9
		<input type="checkbox"/> 10-15	<input type="checkbox"/> more than 15

NEXT STAGE: WOULD YOU BE WILLING TO TAKE PART?

Over the coming months, we will be inviting staff like you to speak to a member of the research team to tell us more about your well being. It would really help us to know if you would like to take part in the next stage of the research.

Taking part means talking to the researcher face to face or over the telephone one to one. You will be asked to share your views on staff well being. Anything you say will be confidential, and anonymised once we have spoken to you (your name will not be used).

Agreement to participate now will not be binding in the future and you will be free to withdraw at any stage. You will be able to speak to the researcher for up to an hour at a time and place convenient for you and, with your permission, the conversation will be audio-taped.

- I would be interested in taking part in next phase of the research study
- I am not interested in taking part

Date

If you are interested in taking part or in discussing this further please complete the following details which will help us contact you at a convenient time. This sheet will be detached from your completed questionnaire to ensure your anonymity.

Your name:

Your telephone number:

Your email address:

I would prefer to be contacted by: telephone email either

If you prefer telephone contact, the best times to contact me are:

.....

If you have any questions or queries please do not hesitate to contact Dr Jill Maben on 020 7848 3057 or at jill.2.maben@kcl.ac.uk

THANK YOU VERY MUCH FOR YOUR HELP

Appendix 11 Measures for variables in main analysis

Patient care performance measures

Although a number of measures of patient care quality have been proposed in the health-related literature (358), to our knowledge, there are no generally accepted and validated scales in this area. Moreover, none of the existing measures capture the different aspects of patient care behaviour and performance we are interested in here. Consequently, to measure the different aspects of PCBP in our model we used scales that we developed specifically for the present study.

In-role performance:

Based on Shaller’s (96) concept of patient-centred care, we identified 6 main dimensions of high quality patient care that relate to nursing jobs but apply also to other direct-contact employees. The six dimensions of patient care include: showing compassion and empathy towards patients, informing and communicating with patients, ensuring the physical comfort of patients, providing emotional support to patients, involving the family and friends of patients, and coordinating care and support for patients. We measured relational and functional in-role patient care performance by asking direct contact employees to rate their own effectiveness on 12 specific tasks linked to the six core dimensions of patient care (two tasks per dimension). Effectiveness on each of the 12 task items was assessed with a nine-point scale (1= not very effective, 5= about average, 9 = very effective). The 12 items involved are shown in Table 47, along with eight additional items designed to tap different aspects of discretionary patient care performance. Exploratory factor analysis (EFA) of the 20 items at time 2 yielded four factors (see Table 47), corresponding to the four main aspects of patient care performance that are the focus of the present analysis. The factors linked to discretionary performance are discussed later. First we consider the two factors linked to in-role performance.

Table 23. Exploratory factor analysis of job performance items

Items	Factor 1	Factor 2	Factor 3	Factor 4
<i>Relational Performance (effectiveness ratings)</i>				
Communicating with patients’ families and friends	.86			
Relieving patients’ fears and anxieties	.85			
Communicating with patients	.79			

Comforting patients in distress	.76			
Winning the trust and cooperation of patients' family and friends	.76			
Providing emotional support to patients	.66			
Looking after the physical comfort of patients	.65			
Responding to patients' need and preferences	.64			
<i>Functional Performance (effectiveness ratings)</i>				
Helping to coordinate care and support from other services		.85		
Arranging transfer of patients to other services		.81		
Providing feedback to patients about their progress		.74		
Helping patients to manage and control pain		.69		
<i>Helping Behaviour</i>				
I often go out of my way to help patients			.80	
I am always ready to go the 'extra mile' for patients			.74	
I often do more for my patients than is formally required of me			.71	
No matter how I feel, I always put myself out for patients			.69	
I give a lot of thought to the needs of my patients			.52	
<i>Continuous Improvement Behaviour</i>				
I often make suggestion about how to improve patient care in our area				.87
I have specific ideas about how to improve patient care in our area				.82
I make it my business to think of ways of improving patient care in our area				.77

Only factor loadings above 0.40 are reported in the table.

The first of these factors includes what can be viewed primarily as relational tasks (e.g. comforting patients in distress, providing emotional support to patients), while the second factor includes more functionally oriented activities (e.g. arranging the transfer of patients to other services, helping patients to manage and control pain) (see Table 47). On this basis, therefore, we combined the items from the first factor into an overall scale of relational patient care performance, and those from the second factor into an overall scale of functional patient care performance. Both scales

showed good internal consistency reliability (Time 2 α : relational performance = 0.91, functional performance = 0.85). In order to obtain an overall measure of in-role performance for use in the analysis, we also combined the relational and functional performance scales into an overall scale of in-role patient care performance. This scale also exhibited good internal reliability (Time 2 α = 0.80).

In this context it is important to note that at time 2, for a subsample of 62 respondents in our panel sample, we were able to obtain assessments of both their in-role relational and functional performance from their direct supervisors. There is considerable debate in the literature as to the relative merits of self-ratings versus supervisory ratings of job performance (359). A potential disadvantage of self-ratings, for example, is that employees have been shown consistently to overestimate their own performance compared to supervisors (360). On the other hand, supervisors may not always be the best judges of performance since they may not necessarily be aware of subordinates' performance across all the tasks they engage in on a daily basis (51). A detailed comparison of employees' own ratings of their relational and functional in-role patient care performance with the ratings of their direct supervisors is provided in Appendix 23. Here it is sufficient to note, first, that employee self-ratings and supervisor ratings of performance are moderately positively correlated ($r = 0.31$). And second that, on average, employee self-ratings are not more positive than supervisor ratings. If anything, in fact, the self-ratings tend to be consistently lower than the supervisor ratings, suggesting that performance self-ratings in the present study may not be particularly subject to inflation bias and may, therefore, be a reasonable reflection of employees' actual in-role performance. In the main analysis, therefore, we use employees' own rating of their performance to test our model since this enables us to make use of the full panel sample.

Discretionary performance:

To measure discretionary performance we adapted and extended Peccei and Rosenthal's (49) six-item customer-oriented behaviour scale covering both employee helping and continuous improvement behaviours towards customers. Specifically, as shown in Table 47, helping behaviour towards patients was measured with five items (e.g. 'I often do more for my patients than is formally required of me'), while continuous improvement behaviour was measured with three items (e.g. 'I make it my business to think of ways of improving patient care in my area'). All items were measured with a five-point agree-disagree Likert scale (1 = strongly disagree, 5 = strongly agree).

As noted, in exploratory factor analysis of the time 2 data, the items designed to measure helping and continuous improvement behaviour loaded on separate factors, not only from each other, but also from the items measuring relational and functional in-role performance (see Table 47). On this basis, therefore, we combined the five helping behaviour items into an

overall scale of helping behaviour towards patients, and the three continuous improvement items into an overall scale of continuous improvement behaviour towards patients. Both scales showed good internal reliability (Time 2 α : helping behaviour = 0.79, continuous improvement = 0.78). We also constructed an overall measure of discretionary performance by combining the helping behaviour and continuous improvement scales. This overall discretionary performance scale exhibited low but acceptable internal reliability (Time 2 α = 0.62).

In summary, the EFA results suggest that relational performance, functional performance, helping behaviour and continuous improvement behaviour are separate constructs measuring distinct aspects of patient care performance. For the present analysis, however, we also constructed an overall measure of patient care performance by combining the four individual performance scales outlined above (i.e. the relational, functional, helping and continuous improvement measures). This global performance scale showed adequate internal reliability (Time 2 α = 0.71).

Employee wellbeing measures

Job satisfaction:

This was measured with a single item designed to assess respondents' overall satisfaction with their job. Satisfaction was measured with a five-point Likert scale (1 = very dissatisfied, 5 = very satisfied).

Positive affect and negative affect:

Following Warr (250), we measured positive affect by asking respondents how much of the time, over the past few weeks, their job had made them feel optimistic, calm, relaxed, enthusiastic, contented and cheerful. Negative affect, on the other hand, was measured by asking respondents how much of the time, over the past few weeks, their job had made them feel tense, miserable, depressed, worried, uneasy and gloomy (250). Responses on all positive and negative affect items were scored on a five-point frequency scale (1 = never to 5 = all of the time). The six positive affect items were combined into an overall scale of positive affect, while the six negative affect items were combined into an overall scale of negative affect. Both scales showed high internal reliability (Time 1 α : positive affect = 0.8; negative affect = 0.88). To reduce the number of variables in the analysis we constructed an overall measure of relative positive affect at work by subtracting the score on the negative affect scale from that on the positive affect scale. The higher the score on this new variable the greater the level of positive affect relative to negative affect. It is this new overall measure of relative positive affect that we use in the main analysis.

Emotional exhaustion:

We measured this variable with eight emotional exhaustion items adapted from Maslach, Jackson and Leiter's (361) burnout inventory. Sample items include, 'I feel emotionally drained from my work', and 'I feel burned out

from my work'. Responses were scored on a five-point frequency scale (1 = not at all, 5 = very often). The eight items were combined into an overall measure of emotional exhaustion that showed high internal reliability (Time 1 $\alpha = 0.92$).

Climate for patient care measures

Organisational climate for patient care:

We measured this variable with an adapted version of Schneider et al.'s (237) six-item organisational level customer service climate scale. Sample items include ratings of 'The recognition and rewards staff receive for the delivery of high quality care to patients in the organisation' and of 'The leadership shown by management in supporting high quality patient care in the organisation'. Ratings were based on a five-point scale (1 = very poor, 5 = very good). The six items were combined in an overall scale of organisational climate (for patient care) which exhibited adequate internal reliability (Time 1 $\alpha = 0.78$).

Local climate for patient care:

This was measured with three items adapted from Peccei and Rosenthal's (49) co-worker commitment to customer service scale. Sample items include, 'Most of my co-workers put a lot of effort into trying to provide high quality care to patients', and 'Most of my co-workers go out of their way for patients'. Responses were scored on a five-point agree-disagree Likert scale (1 = strongly disagree, 5 = strongly agree). The three items were combined into an overall local climate (for patient care) scale which showed adequate internal reliability (Time 1 $\alpha = 0.79$).

Individual difference measures

Affective patient orientation:

This was measured with three items adapted from Peccei and Rosenthal's (44) affective customer orientation scale. Sample items include, 'I get a lot of satisfaction from dealing with patients', and 'Helping patients is the most rewarding part of my job'. Responses were scored on a five-point agree-disagree Likert scale (1 = strongly disagree, 5 = strongly agree). The three items were combined into an overall affective patient orientation scale which exhibited relatively low, but acceptable internal reliability (Time 1 $\alpha = 0.68$).

Work dedication:

This was measured with Schaufeli et al. (319) four-item work engagement subscale from the Utrecht Work Engagement Scale. Sample items include, 'I find the work that I do full of meaning and purpose', and 'I am enthusiastic about my job'. Responses were scored on a five-point agree-disagree Likert scale (1 = strongly disagree, 5 = strongly agree). The overall four-item work dedication scale had good internal reliability (Time 1 $\alpha = 0.86$).

Job skills and competence:

We measured this variable with four items adapted from Peccei and Rosenthal's (49) job competence scale designed for customer service employees. Sample items include, 'I have the skills necessary to deal with all patient needs', and 'I am confident in my ability to do my job'. Responses were scored on a five-point agree-disagree Likert scale (1 = strongly disagree, 5 = strongly agree). The overall four-item skills and competence scale showed good internal reliability (Time 1 $\alpha = 0.81$).

Job demands-resources measures

Job demands:

This variable was measured with four items adapted from Caplan, Cobb, French, Harrison and Pinnaeau's (1980) (290) workload demands scale and an additional item on monitoring demands from Jackson, Wall, Martin and Davids (362). Sample items include, 'My job requires that I work very hard', and 'I often have too much work to do on my job'. The five items were combined into an overall job demands scale.

Job control:

This was measured with four items from Wall, Jackson and Mullarkey's (320) job control scale. Sample items include, 'The extent you can determine the methods and procedures you use in your work', and 'The extent you can decide on your own how you go about doing your work'. Responses were scored on a five-point scale ranging from 'not at all' (=1), to 'to a very great extent' (= 5). The items were combined into an overall job control scale.

Perceived organisational support:

We measured this variable with the short version of Eisenberger et al.'s (291) POS scale (363). Sample items include, 'This organisation really cares for my wellbeing', and 'This organisation values my contribution to its wellbeing'. The eight items were combined into an overall POS scale.

Supervisor support:

This was measured with the five item supervisory support and consideration scale used in national NHS surveys which, in turn, is based on the Michigan supportive and participative leadership scale. Sample items include, 'My immediate manager helps me when my workload is not manageable', and 'My immediate manager asks for my opinion before making decisions that affect my work'. The items were combined into an overall scale of supervisor support.

Co-worker support:

We measured this variable with Price, Mueller and Currivan's (321) three item scale of co-worker support. Sample items include, 'My co-workers are

willing to listen to my job related problems', and 'My co-workers are helpful to me in getting my job done'.

Job clarity:

This was measured with Price, Mueller and Currivan's (321)four- item scale of job clarity. Sample items include, 'I know exactly what is expected of me in my job', and 'I have clear, planned goals and objectives for my job'.

Control variables

Because of the relatively small size of the panel sample, we sought to limit the number of control variables in the analysis. In preliminary analysis we considered the relationship of a number of possible controls with both the dependent and antecedent variables in our model. The possible controls involved included respondents' job tenure, gender, age, occupational status, general psychological wellbeing as measured by the General Health Questionnaire (GHQ-12), whether they worked in a team, and whether they had any supervisory responsibilities. Except for supervisory responsibility, none of the other variables were systematically related to both the antecedents and the dependent variables in the model. Hence, the only control we included in the main analysis was the supervisory responsibility variable.

Appendix 12 Descriptive statistics for staff survey measures

Table 24. Wellbeing

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Job satisfaction	EAU	44	3.59	0.82	0.12	3.34	3.84	2.00	5.00
	Maternity	78	4.09	0.71	0.08	3.93	4.25	2.00	5.00
	M for E	65	3.89	0.95	0.12	3.66	4.13	1.00	5.00
	Haematology	16	3.94	0.77	0.19	3.53	4.35	2.00	5.00
	ACNS1	28	3.29	1.12	0.21	2.85	3.72	1.00	5.00
	CMS	8	3.63	1.06	0.38	2.74	4.51	2.00	5.00
	ACNS2	26	4.19	0.75	0.15	3.89	4.49	3.00	5.00
	RRT	31	3.71	0.97	0.17	3.35	4.07	1.00	5.00
	Total	296	3.84	0.90	0.05	3.74	3.95	1.00	5.00
Positive affect	EAU	45	2.91	0.68	0.10	2.71	3.12	1.33	4.50
	Maternity	79	3.33	0.71	0.08	3.17	3.49	1.50	4.50
	M for E	66	3.27	0.77	0.09	3.08	3.46	1.33	4.83
	Haematology	16	2.99	0.60	0.15	2.67	3.31	1.83	4.00
	ACNS1	29	2.95	0.94	0.17	2.60	3.31	1.00	5.00
	CMS	8	3.18	0.99	0.35	2.35	4.00	2.00	4.50
	ACNS2	27	3.27	0.71	0.14	2.98	3.55	1.33	4.33
	RRT	31	3.25	0.65	0.12	3.02	3.49	1.83	4.67
	Total	301	3.18	0.75	0.04	3.10	3.27	1.00	5.00
Negative affect	EAU	45	2.13	0.73	0.11	1.91	2.35	1.00	4.17
	Maternity	79	1.90	0.56	0.06	1.78	2.03	1.00	3.17
	M for E	64	2.04	0.71	0.09	1.86	2.22	1.00	4.67
	Haematology	16	2.39	0.74	0.18	1.99	2.78	1.17	4.00
	ACNS1	29	2.18	0.81	0.15	1.87	2.49	1.00	3.50
	CMS	8	2.13	0.72	0.26	1.52	2.73	1.50	3.33
	ACNS2	27	1.97	0.57	0.11	1.74	2.19	1.17	3.33
	RRT	31	2.04	0.73	0.13	1.77	2.31	1.00	4.00
	Total	299	2.05	0.68	0.04	1.97	2.12	1.00	4.67
Emotional exhaustion	EAU	45	2.95	0.96	0.14	2.66	3.24	1.00	5.00
	Maternity	79	2.65	0.75	0.08	2.48	2.82	1.25	4.75
	M for E	65	2.72	0.87	0.11	2.51	2.94	1.25	5.00
	Haematology	16	2.76	0.77	0.19	2.35	3.17	1.50	4.38
	ACNS1	29	2.76	0.94	0.18	2.40	3.12	1.00	4.13
	CMS	8	2.58	0.53	0.19	2.13	3.02	1.88	3.38
	ACNS2	27	2.47	0.74	0.14	2.17	2.76	1.00	4.13
	RRT	31	2.49	0.96	0.17	2.14	2.84	1.00	4.75
	Total	300	2.69	0.85	0.05	2.60	2.79	1.00	5.00

Test of Homogeneity of Variances

	Levene Statistic	df1	df2	Sig.
Job satisfaction	2.513	7	288	.016
Positive affect	1.557	7	293	.148
Negative affect	1.402	7	291	.204
Emotional exhaustion	1.462	7	292	.181

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Job satisfaction	Between Groups	20.645	7	2.949	3.893	.000
	Within Groups	218.207	288	.758		
	Total	238.851	295			
Positive affect	Between Groups	7.958	7	1.137	2.076	.046
	Within Groups	160.428	293	.548		
	Total	168.386	300			
Negative affect	Between Groups	4.535	7	.648	1.400	.205
	Within Groups	134.697	291	.463		
	Total	139.232	298			
Emotional exhaustion	Between Groups	6.185	7	.884	1.222	.290
	Within Groups	211.076	292	.723		
	Total	217.261	299			

Robust Tests of Equality of Means

		Statistic ^a	df1	df2	Sig.
Job satisfaction	Welch	3.516	7	65.003	.003
	Brown-Forsythe	3.564	7	115.217	.002
Positive affect	Welch	2.085	7	66.247	.057
	Brown-Forsythe	1.921	7	95.183	.075
Negative affect	Welch	1.349	7	65.598	.242
	Brown-Forsythe	1.304	7	140.220	.253
Emotional exhaustion	Welch	1.078	7	68.232	.387
	Brown-Forsythe	1.300	7	208.369	.252

Table 25. Organisational and local work-group climate

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Organisational climate	EAU	45	3.12	0.60	0.09	2.94	3.30	1.50	4.67
	Maternity	79	3.56	0.57	0.06	3.43	3.69	2.17	4.83
	M for E	66	3.60	0.69	0.08	3.43	3.77	1.83	5.00
	Haematology	16	3.73	0.38	0.10	3.52	3.93	2.83	4.33
	ACNS1	29	3.24	0.87	0.16	2.91	3.58	1.50	4.83
	CMS	8	3.15	0.58	0.21	2.66	3.63	2.33	3.83
	ACNS2	27	3.74	0.46	0.09	3.56	3.92	2.50	4.67
	RRT	31	3.75	0.82	0.15	3.45	4.05	1.83	5.00
	Total	301	3.51	0.68	0.04	3.43	3.58	1.50	5.00
Local climate	EAU	45	4.05	0.48	0.07	3.91	4.20	3.00	5.00
	Maternity	78	4.27	0.52	0.06	4.16	4.39	3.00	5.00
	M for E	66	4.09	0.62	0.08	3.93	4.24	2.00	5.00
	Haematology	16	4.38	0.80	0.20	3.95	4.80	2.00	5.00
	ACNS1	29	3.82	0.76	0.14	3.53	4.11	2.33	5.00
	CMS	8	4.33	0.71	0.25	3.74	4.93	3.00	5.00
	ACNS2	27	4.54	0.48	0.09	4.35	4.73	3.67	5.00
	RRT	31	4.11	0.69	0.12	3.85	4.36	1.67	5.00
	Total	300	4.17	0.62	0.04	4.10	4.24	1.67	5.00

Test of Homogeneity of Variances

	Levene Statistic	df1	df2	Sig.
Organisational climate	4.072	7	293	.000
Local climate	2.059	7	292	.048

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Organisational climate	Between Groups	14.693	7	2.099	4.985	.000
	Within Groups	123.373	293	.421		
	Total	138.066	300			
Local climate	Between Groups	10.330	7	1.476	4.100	.000
	Within Groups	105.112	292	.360		
	Total	115.443	299			

Robust Tests of Equality of Means

		Statistic ^a	df1	df2	Sig.
Organisational climate	Welch	5.530	7	67.783	.000
	Brown-Forsythe	5.135	7	157.647	.000
Local climate	Welch	4.142	7	65.208	.001
	Brown-Forsythe	3.502	7	109.483	.002

a. Asymptotically F distributed.

Table 26. Individual differences

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum	
					Lower Bound	Upper Bound			
Affective patient orientation	EAU	45	4.30	0.48	0.07	4.15	4.44	3.33	5.00
	Maternity	79	4.35	0.39	0.04	4.27	4.44	3.00	5.00
	M for E	66	4.48	0.43	0.05	4.37	4.59	2.67	5.00
	Haematology	16	4.33	0.49	0.12	4.07	4.59	3.00	5.00
	ACNS1	29	4.45	0.49	0.09	4.26	4.63	3.33	5.00
	CMS	8	4.38	0.45	0.16	4.00	4.75	4.00	5.00
	ACNS2	27	4.44	0.67	0.13	4.18	4.71	2.00	5.00
	RRT	31	4.31	0.51	0.09	4.13	4.50	3.33	5.00
	Total	301	4.39	0.47	0.03	4.33	4.44	2.00	5.00
Work dedication	EAU	45	3.98	0.51	0.08	3.83	4.13	2.75	5.00
	Maternity	79	4.31	0.47	0.05	4.20	4.41	2.75	5.00
	M for E	66	4.36	0.58	0.07	4.22	4.51	1.25	5.00
	Haematology	16	4.20	0.49	0.12	3.94	4.47	3.25	5.00
	ACNS1	29	4.12	0.42	0.08	3.96	4.28	3.50	5.00
	CMS	8	4.13	0.48	0.17	3.72	4.53	3.75	5.00
	ACNS2	27	4.21	0.47	0.09	4.03	4.40	3.00	5.00
	RRT	31	4.11	0.62	0.11	3.88	4.34	2.50	5.00
	Total	301	4.21	0.53	0.03	4.15	4.27	1.25	5.00
Skills and competence	EAU	45	4.21	0.42	0.06	4.08	4.33	3.00	5.00
	Maternity	79	4.23	0.51	0.06	4.12	4.34	2.75	5.00
	M for E	66	4.30	0.54	0.07	4.17	4.44	2.50	5.00
	Haematology	16	4.06	0.51	0.13	3.79	4.34	3.00	5.00
	ACNS1	29	3.98	0.55	0.10	3.77	4.19	3.00	5.00
	CMS	8	3.63	0.88	0.31	2.89	4.36	2.00	4.25
	ACNS2	27	4.06	0.51	0.10	3.86	4.27	2.50	4.75
	RRT	31	4.31	0.42	0.08	4.16	4.47	3.50	5.00
	Total	301	4.19	0.53	0.03	4.13	4.25	2.00	5.00

Test of Homogeneity of Variances

	Levene Statistic	df1	df2	Sig.
Affective patient orientation	1.176	7	293	.316
Work dedication	.701	7	293	.671
Skills and competence	1.597	7	293	.136

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Affective patient orientation	Between Groups	1.442	7	.206	.920	.491
	Within Groups	65.631	293	.224		
	Total	67.073	300			
Work dedication	Between Groups	5.205	7	.744	2.783	.008
	Within Groups	78.269	293	.267		
	Total	83.474	300			
Skills and competence	Between Groups	6.030	7	.861	3.270	.002
	Within Groups	77.177	293	.263		
	Total	83.207	300			

Robust Tests of Equality of Means

		Statistic ^a	df1	df2	Sig.
Affective patient orientation	Welch	.901	7	65.437	.511
	Brown-Forsythe	.828	7	148.587	.565
Work dedication	Welch	2.590	7	66.826	.020
	Brown-Forsythe	2.879	7	165.837	.007
Skills and competence	Welch	2.184	7	65.704	.047
	Brown-Forsythe	2.690	7	54.931	.018

a. Asymptotically F distributed.

Table 27. Job demand and resources

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum	
					Lower Bound	Upper Bound			
Job demands	EAU	45	4.15	0.57	0.08	3.98	4.32	2.80	5.00
	Maternity	79	4.08	0.52	0.06	3.96	4.19	3.00	5.00
	M for E	66	4.17	0.62	0.08	4.02	4.32	2.75	5.00
	Haematology	16	4.18	0.50	0.13	3.91	4.45	3.20	5.00
	ACNS1	29	3.98	0.62	0.12	3.74	4.22	2.80	5.00
	CMS	8	3.88	0.68	0.24	3.31	4.44	2.60	4.60
	ACNS2	27	3.95	0.59	0.11	3.71	4.18	2.80	4.80
	RRT	31	3.70	0.57	0.10	3.49	3.91	2.75	5.00
	Total	301	4.05	0.59	0.03	3.98	4.11	2.60	5.00
Job control	EAU	44	2.68	0.81	0.12	2.43	2.92	1.25	4.50
	Maternity	78	2.91	0.84	0.09	2.72	3.10	1.50	4.75
	M for E	66	2.96	0.93	0.11	2.73	3.19	1.00	5.00
	Haematology	16	2.63	0.75	0.19	2.23	3.02	1.50	4.25
	ACNS1	28	2.74	0.92	0.17	2.38	3.09	1.00	5.00
	CMS	8	3.63	0.79	0.28	2.96	4.29	2.25	4.75
	ACNS2	27	3.24	0.82	0.16	2.92	3.56	1.75	5.00
	RRT	31	2.97	0.78	0.14	2.69	3.26	1.50	4.75
	Total	298	2.91	0.86	0.05	2.81	3.01	1.00	5.00
POS	EAU	45	2.56	0.63	0.09	2.37	2.74	1.13	4.00
	Maternity	79	2.91	0.55	0.06	2.79	3.03	1.38	4.13
	M for E	66	3.12	0.75	0.09	2.94	3.30	1.13	4.88
	Haematology	16	3.06	0.84	0.21	2.61	3.51	1.00	4.13
	ACNS1	29	2.90	0.94	0.17	2.55	3.26	1.00	5.00
	CMS	8	3.13	0.78	0.28	2.47	3.78	2.00	4.00
	ACNS2	27	3.31	0.55	0.11	3.09	3.52	2.38	4.25
	RRT	31	3.10	0.73	0.13	2.83	3.36	1.50	4.38
	Total	301	2.97	0.72	0.04	2.89	3.05	1.00	5.00
Supervisor support	EAU	45	3.20	0.90	0.13	2.93	3.48	1.20	5.00
	Maternity	79	3.70	0.84	0.09	3.51	3.89	1.20	5.00
	M for E	66	3.82	1.01	0.12	3.57	4.07	1.00	5.00
	Haematology	16	3.96	0.67	0.17	3.60	4.32	2.80	5.00
	ACNS1	29	3.34	1.09	0.20	2.93	3.76	1.00	5.00
	CMS	8	3.20	0.65	0.23	2.66	3.74	2.40	4.00
	ACNS2	27	3.99	0.69	0.13	3.71	4.26	2.40	5.00
	RRT	30	3.31	0.93	0.17	2.96	3.65	1.40	5.00
	Total	300	3.60	0.93	0.05	3.50	3.71	1.00	5.00
Co-worker support	EAU	45	4.00	0.52	0.08	3.84	4.16	2.33	5.00
	Maternity	78	4.21	0.56	0.06	4.08	4.33	2.33	5.00
	M for E	66	3.83	0.81	0.10	3.63	4.03	1.00	5.00
	Haematology	16	4.10	0.57	0.14	3.80	4.41	3.00	5.00
	ACNS1	29	3.55	0.74	0.14	3.27	3.83	1.67	5.00
	CMS	8	3.88	0.83	0.30	3.18	4.57	2.00	4.67
	ACNS2	27	4.48	0.48	0.09	4.29	4.67	3.67	5.00
	RRT	31	4.08	0.69	0.12	3.82	4.33	2.00	5.00
	Total	300	4.03	0.69	0.04	3.95	4.10	1.00	5.00
Job clarity	EAU	45	3.96	0.57	0.08	3.78	4.13	2.25	5.00
	Maternity	79	4.20	0.45	0.05	4.10	4.29	2.75	5.00
	M for E	66	4.29	0.57	0.07	4.15	4.43	2.75	5.00
	Haematology	16	4.08	0.34	0.08	3.90	4.26	3.50	4.75
	ACNS1	29	3.85	0.65	0.12	3.61	4.10	2.25	5.00
	CMS	8	3.59	0.79	0.28	2.93	4.25	2.00	4.25
	ACNS2	27	4.06	0.61	0.12	3.82	4.30	2.75	5.00
	RRT	31	3.84	0.68	0.12	3.59	4.09	2.00	4.75
	Total	301	4.08	0.59	0.03	4.01	4.14	2.00	5.00

Test of Homogeneity of Variances

	Levene Statistic	df1	df2	Sig.
Job demands	.683	7	293	.686
Job control	.656	7	290	.710
POS	1.985	7	293	.057
Supervisor support	1.264	7	292	.268
Co-worker support	1.925	7	292	.065
Job clarity	2.117	7	293	.042

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Job demands	Between Groups	6.160	7	.880	2.654	.011
	Within Groups	97.140	293	.332		
	Total	103.300	300			
Job control	Between Groups	11.884	7	1.698	2.345	.024
	Within Groups	209.905	290	.724		
	Total	221.788	297			
POS	Between Groups	13.527	7	1.932	4.025	.000
	Within Groups	140.658	293	.480		
	Total	154.185	300			
Supervisor support	Between Groups	22.888	7	3.270	4.007	.000
	Within Groups	238.293	292	.816		
	Total	261.181	299			

Co-worker support	Between Groups	17.463	7	2.495	5.849	.000
	Within Groups	124.546	292	.427		
	Total	142.009	299			
Job clarity	Between Groups	9.898	7	1.414	4.462	.000
	Within Groups	92.850	293	.317		
	Total	102.748	300			

Robust Tests of Equality of Means

		Statistic ^a	df1	df2	Sig.
Job demands	Welch	2.479	7	66.137	.025
	Brown-Forsythe	2.546	7	125.222	.017
Job control	Welch	2.471	7	66.768	.026
	Brown-Forsythe	2.470	7	171.072	.019
POS	Welch	4.699	7	65.201	.000
	Brown-Forsythe	3.538	7	120.385	.002
Supervisor support	Welch	4.439	7	68.133	.000
	Brown-Forsythe	4.450	7	203.298	.000
Co-worker support	Welch	6.030	7	66.095	.000
	Brown-Forsythe	5.633	7	101.647	.000
Job clarity	Welch	3.490	7	66.151	.003
	Brown-Forsythe	3.903	7	89.318	.001

a. Asymptotically F distributed.

Table 28. Job performance variables

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Relational performance	EAU	45	7.31	1.02	0.15	7.00	7.61	4.88	9.00
	Maternity	79	7.72	0.81	0.09	7.54	7.90	5.00	9.00
	M for E	66	7.68	0.99	0.12	7.43	7.92	5.25	9.00
	Haematology	16	7.52	0.81	0.20	7.08	7.95	5.63	8.63
	ACNS1	29	7.48	1.18	0.22	7.03	7.92	4.38	9.00
	CMS	8	7.30	0.94	0.33	6.51	8.08	5.38	8.25
	ACNS2	27	7.50	0.73	0.14	7.21	7.79	5.63	9.00
	RRT	31	7.42	1.08	0.19	7.03	7.82	4.50	8.75
	Total	301	7.55	0.95	0.05	7.44	7.66	4.38	9.00
Functional performance	EAU	44	6.61	1.53	0.23	6.15	7.08	1.25	9.00
	Maternity	79	7.29	1.20	0.14	7.02	7.56	1.00	9.00
	M for E	65	7.13	1.31	0.16	6.80	7.45	3.00	9.00
	Haematology	15	6.97	0.70	0.18	6.58	7.35	5.75	8.25
	ACNS1	29	6.95	1.01	0.19	6.57	7.33	5.00	9.00
	CMS	8	7.34	0.92	0.32	6.58	8.11	5.75	9.00
	ACNS2	27	7.10	1.16	0.22	6.64	7.56	4.25	9.00
	RRT	31	6.83	1.18	0.21	6.40	7.27	4.00	8.75
	Total	298	7.04	1.24	0.07	6.90	7.18	1.00	9.00
Helping behaviour	EAU	45	3.88	0.52	0.08	3.72	4.04	2.00	5.00
	Maternity	77	3.94	0.43	0.05	3.85	4.04	3.00	5.00
	M for E	66	4.12	0.49	0.06	3.99	4.24	3.00	5.00
	Haematology	16	3.98	0.43	0.11	3.75	4.20	3.20	4.80
	ACNS1	29	4.01	0.50	0.09	3.82	4.20	3.00	5.00
	CMS	8	3.50	0.39	0.14	3.18	3.82	3.00	4.00
	ACNS2	27	3.99	0.55	0.11	3.77	4.20	2.60	5.00
	RRT	31	3.93	0.54	0.10	3.73	4.13	3.00	5.00
	Total	299	3.97	0.49	0.03	3.91	4.03	2.00	5.00
Continuous performance	EAU	45	3.41	0.67	0.10	3.21	3.61	1.67	4.67
	Maternity	77	3.45	0.55	0.06	3.32	3.58	2.00	5.00
	M for E	66	3.91	0.63	0.08	3.75	4.06	2.33	5.00
	Haematology	16	3.63	0.82	0.20	3.19	4.06	2.00	5.00
	ACNS1	29	3.56	0.71	0.13	3.29	3.83	2.00	5.00
	CMS	8	3.83	0.64	0.23	3.30	4.37	2.67	4.33
	ACNS2	27	3.62	0.66	0.13	3.36	3.88	2.00	4.67
	RRT	30	3.73	0.58	0.11	3.52	3.95	2.67	5.00
	Total	298	3.62	0.65	0.04	3.54	3.69	1.67	5.00
In role performance	EAU	45	6.94	1.09	0.16	6.62	7.27	4.00	9.00
	Maternity	79	7.51	0.92	0.10	7.30	7.71	4.50	9.00
	M for E	66	7.41	1.04	0.13	7.15	7.66	5.00	9.00
	Haematology	16	7.28	0.72	0.18	6.90	7.66	6.06	8.44
	ACNS1	29	7.21	1.00	0.19	6.83	7.59	4.69	9.00
	CMS	8	7.32	0.90	0.32	6.57	8.07	5.56	8.63
	ACNS2	27	7.30	0.85	0.16	6.96	7.64	5.69	9.00
	RRT	31	7.13	1.07	0.19	6.74	7.52	4.25	8.69
	Total	301	7.30	0.99	0.06	7.19	7.41	4.00	9.00
Discretionary performance	EAU	45	3.64	0.50	0.07	3.49	3.79	2.33	4.63
	Maternity	77	3.70	0.42	0.05	3.60	3.79	2.67	4.83
	M for E	66	4.01	0.49	0.06	3.89	4.13	2.87	5.00
	Haematology	16	3.80	0.53	0.13	3.52	4.08	2.70	4.70
	ACNS1	29	3.79	0.51	0.09	3.59	3.98	2.67	5.00
	CMS	8	3.67	0.44	0.16	3.30	4.04	2.93	4.17
	ACNS2	27	3.80	0.52	0.10	3.60	4.01	2.60	4.73
	RRT	31	3.84	0.43	0.08	3.68	3.99	2.83	4.90
	Total	299	3.80	0.48	0.03	3.74	3.85	2.33	5.00
Overall performance	EAU	45	5.29	0.69	0.10	5.08	5.49	3.42	6.69
	Maternity	79	5.64	0.61	0.07	5.51	5.78	3.63	7.19
	M for E	66	5.70	0.71	0.09	5.52	5.87	4.25	7.00
	Haematology	16	5.49	0.55	0.14	5.19	5.78	4.71	6.42
	ACNS1	29	5.50	0.67	0.12	5.24	5.76	3.83	7.00
	CMS	8	5.49	0.60	0.21	4.99	5.99	4.53	6.25
	ACNS2	27	5.55	0.60	0.12	5.31	5.79	4.39	6.87
	RRT	31	5.50	0.69	0.12	5.25	5.76	4.05	6.83
	Total	301	5.55	0.66	0.04	5.48	5.63	3.42	7.19

Test of Homogeneity of Variances

	Levene Statistic	df1	df2	Sig.
Relational performance	1.238	7	293	.282
Functional performance	1.245	7	290	.278
Helping behaviour	.789	7	291	.597
Continuous performance	1.002	7	290	.430
In role performance	.515	7	293	.823
Discretionary performance	.519	7	291	.820
Overall performance	.446	7	293	.872

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Relational performance	Between Groups	7.283	7	1.040	1.151	.332
	Within Groups	264.984	293	.904		
	Total	272.267	300			
Functional performance	Between Groups	16.025	7	2.289	1.502	.166
	Within Groups	442.131	290	1.525		
	Total	458.156	297			
Helping behaviour	Between Groups	3.693	7	.528	2.227	.032
	Within Groups	68.928	291	.237		
	Total	72.621	298			
Continuous performance	Between Groups	10.517	7	1.502	3.729	.001
	Within Groups	116.838	290	.403		
	Total	127.354	297			
In role performance	Between Groups	10.957	7	1.565	1.617	.130
	Within Groups	283.633	293	.968		
	Total	294.590	300			
Discretionary performance	Between Groups	5.037	7	.720	3.220	.003
	Within Groups	65.023	291	.223		
	Total	70.060	298			
Overall performance	Between Groups	5.488	7	.784	1.828	.082
	Within Groups	125.646	293	.429		

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Relational performance	Between Groups	7.283	7	1.040	1.151	.332
	Within Groups	264.984	293	.904		
	Total	272.267	300			
Functional performance	Between Groups	16.025	7	2.289	1.502	.166
	Within Groups	442.131	290	1.525		
	Total	458.156	297			
Helping behaviour	Between Groups	3.693	7	.528	2.227	.032
	Within Groups	68.928	291	.237		
	Total	72.621	298			
Continuous performance	Between Groups	10.517	7	1.502	3.729	.001
	Within Groups	116.838	290	.403		
	Total	127.354	297			
In role performance	Between Groups	10.957	7	1.565	1.617	.130
	Within Groups	283.633	293	.968		
	Total	294.590	300			
Discretionary performance	Between Groups	5.037	7	.720	3.220	.003
	Within Groups	65.023	291	.223		
	Total	70.060	298			
Overall performance	Between Groups	5.488	7	.784	1.828	.082
	Within Groups	125.646	293	.429		
	Total	131.133	300			

under the terms of a commission contract issued by the Secretary of State for Health.

Robust Tests of Equality of Means

		Statistic ^a	df1	df2	Sig.
Relational performance	Welch	1.110	7	66.445	.368
	Brown-Forsythe	1.137	7	155.553	.343
Functional performance	Welch	1.274	7	68.309	.276
	Brown-Forsythe	1.764	7	213.616	.096
Helping behaviour	Welch	2.643	7	66.891	.018
	Brown-Forsythe	2.255	7	190.374	.032
Continuous performance	Welch	3.706	7	65.427	.002
	Brown-Forsythe	3.394	7	134.590	.002
In role performance	Welch	1.408	7	67.489	.216
	Brown-Forsythe	1.728	7	180.344	.105
Discretionary performance	Welch	2.998	7	66.097	.009
	Brown-Forsythe	3.097	7	156.737	.004
Overall performance	Welch	1.598	7	67.099	.151
	Brown-Forsythe	1.919	7	179.300	.069

a. Asymptotically F distributed.

Table 29. Stress and GHQ12

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Job Stress	EAU	45	3.68	0.76	0.11	3.45	3.91	1.67	5.00
	Maternity	79	3.54	0.72	0.08	3.38	3.70	1.67	5.00
	M for E	66	3.53	0.78	0.10	3.34	3.72	1.67	5.00
	Haematology	16	3.85	0.90	0.23	3.37	4.34	2.00	5.00
	ACNS1	29	3.51	0.75	0.14	3.22	3.79	2.00	4.67
	CMS	8	3.71	0.58	0.20	3.23	4.19	2.67	4.33
	ACNS2	27	3.57	0.78	0.15	3.26	3.88	1.67	5.00
	RRT	31	3.32	0.92	0.16	2.99	3.66	1.00	5.00
	Total	301	3.56	0.78	0.04	3.47	3.65	1.00	5.00
GHQ12	EAU	44	1.88	0.47	0.07	1.74	2.02	1.17	3.83
	Maternity	79	1.78	0.27	0.03	1.72	1.84	1.25	2.58
	M for E	66	1.80	0.34	0.04	1.72	1.88	1.25	2.83
	Haematology	16	2.07	0.40	0.10	1.86	2.28	1.50	2.75
	ACNS1	29	1.88	0.49	0.09	1.69	2.06	1.17	3.08
	CMS	8	1.87	0.40	0.14	1.54	2.20	1.36	2.50
	ACNS2	27	1.80	0.27	0.05	1.70	1.91	1.50	2.67
	RRT	31	1.82	0.40	0.07	1.67	1.97	1.25	3.00
	Total	300	1.83	0.37	0.02	1.79	1.88	1.17	3.83

Test of Homogeneity of Variances

	Levene Statistic	df1	df2	Sig.
Job Stress	.477	7	293	.851
GHQ12	2.064	7	292	.047

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Job Stress	Between Groups	4.146	7	.592	.978	.447
	Within Groups	177.458	293	.606		
	Total	181.604	300			
GHQ12	Between Groups	1.410	7	.201	1.497	.168
	Within Groups	39.308	292	.135		
	Total	40.719	299			

Robust Tests of Equality of Means

		Statistic ^a	df1	df2	Sig.
Job Stress	Welch	.778	7	66.979	.608
	Brown-Forsythe	.970	7	172.644	.455
GHQ12	Welch	1.311	7	64.905	.259
	Brown-Forsythe	1.333	7	134.141	.240

a. Asymptotically F distributed.

Appendix 13 Additional analysis procedures

ICC1 values

To check for non-independence in the data we calculated the interclass correlation (ICC1) for all the main measures in our model using site as the clustering variable. The relevant ICC1 values for selected variables are reported in column 1 of Table 30 below, showing the proportion of the variance in each variable that resides at the level of the site, as opposed to the individual level. The higher the ICC1 value the greater the clustering of scores by site and, therefore, the greater the potential problems of non-independence in the data. As can be seen, for a majority of the variables the ICC1 value was zero, or close to zero, indicating virtually no clustering of scores by site and, therefore, no significant problems of non-independence of observations. However, for emotional exhaustion and for a number of the dependent performance variables the ICC1 scores reached 0.09, indicating that about nine percent of the overall variance in these measures resided at the level of the site. Although not particularly high, these scores suggest a certain degree of non-independence of observations for some of the key variables in the model.

Table 30. ICC1 values and stability analysis

Variables	(1) ICC1 Value	(2) Mean Score Time 1	(3) Mean Score Time 2	(4) Difference Score (T2 – T1)	(5) Correlation Between T1 and T2 Scores
Job satisfaction	.00 ^a	3.97	3.93	-0.04	.67***
Emotional exhaustion	.09* ^a	2.63	2.66	0.03	.76***
Positive affect (relative)	.00 ^a	1.27	1.18	-0.09	.64***
Organisational climate	.00 ^a	3.59	3.64	0.05	.75***
Local climate	.03 ^a	4.32	4.22	-0.10	.73***
Affective patient orientation	.00 ^a	4.39	4.40	0.01	.74***
Work dedication	.00 ^a	4.25	4.12	-0.13**	.65***
Skills and competence	.00 ^a	4.25	4.20	-0.05	.67***
Relational performance	.03+ ^b	7.69	7.63	-0.06	.44***

Functional performance	.00 ^b	7.22	7.15	-0.07	.65***
Helping behaviour	.05 ^b	3.99	3.98	-0.01	.83***
Continuous improvement	.09** ^b	3.75	3.67	-0.08	.71***
Overall in-role performance	.00 ^b	7.46	7.39	-0.07	.70***
Overall discretionary performance	.09** ^b	3.87	3.82	-0.05	.65***
Overall performance	.00 ^b	5.67	5.60	-0.07	.66***

^a ICC1 values for all the antecedent variables are for time 1.

^b ICC1 values for all the performance variables are for time 2.

For ICC1, difference in means between sites: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Difference between time 2 and time 1 scores: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Correlation between time 1 and time 2 scores: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Stability analysis

As can be seen from column 4 of Table 30, except for work dedication, the mean score for all the other variables in the table, including the dependent performance variables, did not change significantly between the two occasions of measurement. Moreover, as can be seen from the correlations in the last column of the table, except for local climate ($r = 0.44$, $p < 0.001$), all the correlations between the time 1 and time 2 variables, including the performance variables, were strong, ranging from 0.65 to 0.83. Taken together these results indicate considerable stability over time in the model variables, including the dependent performance measures.

Representativeness of panel sample

To check the representativeness of the panel sample compared to the main sample of employees who took part in the time 1 survey we compared the mean time 1 scores of the panel sample on all the main variables in the model with those of direct-contact employees who took part in the first survey but did not participate in the follow-up survey. For ease of presentation we refer to the second group as the time 1 non-panel sample ($N = 175$). The results of this analysis are shown in Table 31 below. As can be seen, the panel sample, on average, scored significantly higher than the non-panel sample on eight of the 21 variables in the model, suggesting that the panel sample, compared to the initial time 1 sample, tended to be positively biased. In other words, the panel sample is not necessarily representative of the time 1 sample as a whole since the employees who participated in both surveys were ones who tended, on the whole, to exhibit

more positive work attitudes and to report higher levels of patient care performance at time 1.

Table 31. Comparison of panel versus non-panel sample: Mean time 1 scores

Variables	Panel Sample Mean Score Time 1	Non-panel Sample Mean Score Time 1	Panel-Non-panel Sample Difference in Time 1 Score
Job satisfaction	3.98	3.75	0.23*
Emotional exhaustion	2.63	2.74	-0.11
Positive affect (relative)	1.27	1.03	0.24
Organisational climate	3.59	3.45	0.14
Local climate	4.32	4.06	0.25***
Affective patient orientation	4.39	4.38	0.01
Work dedication	4.25	4.18	0.07
Skills and competence	4.25	4.14	0.11
Relational performance	7.67	7.47	0.20
Functional performance	7.22	6.92	0.30*
Helping behaviour	3.98	3.96	0.01
Continuous improvement	3.73	3.54	0.19*
Overall in-role performance	7.44	7.19	0.25*
Overall discretionary performance	3.86	3.75	0.11
Overall performance	5.67	5.47	0.20**
Job demands	4.09	4.01	0.07

Job control	3.11	2.77	0.35**
Perceived organisational support	3.01	2.95	0.06
Supervisor support	3.64	3.58	0.06
Co-worker support	4.14	3.95	0.19*
Job clarity	4.12	4.04	0.07

Difference between panel and non-panel sample:

* $p < 0.05$,

** $p < 0.01$,

*** $p < 0.001$

Later in the report (Appendix 22) we present the results of a set of additional analyses designed to check whether the positive bias in the panel sample may have influenced the results of the main analysis. As we will see in more detail later, the results of this additional set of analyses suggest that the results of the main analysis testing our basic research model are unlikely to have been systematically influenced or distorted by the positive bias in the panel sample, thereby increasing confidence in the validity and generalisability of the results of the main analysis.

Appendix 14 Phase II: Patient experience survey

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For office use only



Patient Experience of Care and Staff Wellbeing

Patient Survey

What is this survey and why are we asking you to complete it?

This is an independent survey of your recent experience in the Emergency Admissions Unit (EAU) and/or (short stay) ward at . The overall aim is to gather information that will help to improve care for patients.

Please complete the survey for your most recent period of care at . The survey will take approximately 15 minutes to complete.

The questions should be answered by the person named on the front of the envelope. Please note that if that person needs help to complete the questionnaire, the answers should be given from his/her point of view - not the point of view of the person who is helping.

Please read each question carefully, but give your immediate response by ticking the box which best matches your personal view.

Who will see my answers?

The survey is being conducted and analysed by Dr Jill Maben and a research team at King's College London (University of London). The results will be presented in a summary report in which no individual, or their responses, can be identified.

The overall results of the survey will be fed back anonymously to the hospital that cared for you to help hospital managers and staff improve local services and to make progress in improving patient experiences.

Your answers will be treated in confidence. No one in the hospital will be able to see your answers or identify individual responses.

Please return this questionnaire, in the envelope provided, to:

Dr Jill Maben
National Nursing Research Unit, King's College London, Freepost Lon1124, London SE1 8YY

If you have any queries about this questionnaire please contact the National Nursing Research Unit at King's College, London on 020 7848 3057 or nnru@kcl.ac.uk

Taking part in this survey is voluntary. If you decide to take part your answers are anonymous (no name) and confidential

1

SECTION A: THE STAFF

During your most recent time in [] you would have come into contact with a number of different hospital staff (eg nurses, doctors, physiotherapists, occupational therapists, pastoral care, social workers, ward clerks, catering staff, cleaning staff etc). Think now about all the staff that you have had contact with during your last admission, and place a tick in the box that best represents your experiences. If you would like to comment about your experiences, please use the comment box provided at the end of the questionnaire.

For example:	All staff	Most staff	Some staff	None
The nurses have told me how I can contact them if I need assistance.		✓		

PLEASE START HERE

		All staff	Most staff	Some staff	None
1	The nurses told me that they were there to help me				
2	The nurses told me how I could contact them if I needed assistance				
3	The staff appeared confident and able to perform specific tasks when caring for other patients or me				
4	I had the opportunity to get to know the staff as people				
5	The staff used opportunities to get to know me as a person				
6	Staff responded quickly and effectively to requests for assistance				
7	Nurses explained with openness and honesty what was happening and what to expect				
8	The doctors (or doctor) explained with openness and honesty what was happening and what to expect				
9	Staff used appropriate eye contact when communicating with me				
10	Staff were neither too close or too far away when they communicated with me				
11	Staff used an appropriate tone of voice when they communicated with me				
12	Staff displayed gentleness and concern when they cared for me				
13	Staff encouraged me when I needed support				
14	I felt that staff really listened to me when I talked				
15	The care that I have received from staff has exceeded my expectations				
16	Staff used appropriate facial expressions when communicating with me				
17	Staff engaged me in social topics of conversation at suitable times				

SECTION B: HOW DID YOU FEEL		Always	Mostly	Sometimes	Never
18	I felt safe during this admission				
19	I had the contact and support from staff that I have needed				
20	I felt informed during this admission. I knew what was happening, what I needed to do and what to expect				
21	I felt valued as a person during this admission				
22	I felt the nurses treated me with courtesy and respect whilst I was in hospital				
23	I felt the doctors treated me with courtesy and respect whilst I was in hospital				
24	Did you have confidence and trust in the doctors treating you?				
25	Did doctors talk in front of you as if you weren't there?				
26	Did you have confidence and trust in the nurses treating you?				
27	Did nurses talk in front of you as if you weren't there?				

SECTION C: OTHER ASPECTS OF YOUR EXPERIENCE

28 In your opinion, were there enough nurses on duty to care for you in hospital?

- There were always or nearly always enough nurses
- There were sometimes enough nurses
- There were rarely enough nurses

29 Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

- Yes often
- Yes sometimes
- No

30 Were you involved as much as you wanted to be in decisions about your care and treatment?

- Yes definitely
- Yes to some extent
- No

31 If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

- Yes definitely
- Yes to some extent
- No
- No family and friends were involved
- My family did not want or need information
- I did not want my family or friends to talk to a doctor

32 Did you find someone on the hospital staff to talk to about your worries and fears?

- Yes definitely
- Yes to some extent
- No
- I had no worries or fears

33 Were you ever in any pain?

- Yes
- No

If yes, do you think the hospital did everything they could to help control your pain?

- Yes definitely
- Yes to some extent
- No

34 I had all the help I needed from staff to eat my meals.

- Yes always
- Yes sometimes
- No

35 How would you rate how well the doctors and nurses worked together?

- Excellent
- Very good
- Good
- Fair
- Poor

36 Did you want to complain about the care you received in hospital?

- ¹ Yes
- ² No

37 When you had important questions to ask a doctor, did you get answers that you could understand?

- ¹ Yes, always
- ² Yes, sometimes
- ³ No
- ⁴ I had no need to ask

38 When you had important questions to ask a nurse, did you get answers that you could understand?

- ¹ Yes, always
- ² Yes, sometimes
- ³ No
- ⁴ I had no need to ask

39 Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?

- ¹ Yes, definitely
- ² Yes, to some extent
- ³ No
- ⁴ No family or friends were involved
- ⁵ My family or friends didn't want or need information

40 Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

- ¹ Yes, completely
- ² Yes, to some extent
- ³ No
- ⁴ I didn't need an explanation
- ⁵ I had no medicines – go to question 42

41 Did a member of staff tell you about medication side effects to watch for when you went home?

- ¹ Yes, completely
- ² Yes, to some extent
- ³ No
- ⁴ I didn't need an explanation

42 Did someone tell you about danger signals regarding your illness or treatment to watch out for after you went home?

- ¹ Yes, completely
- ² Yes, to some extent
- ³ No

43 If you had any anxieties or fears about your condition or treatment, did a doctor discuss them with you?

- ¹ Yes, completely
- ² Yes, to some extent
- ³ No
- ⁴ I didn't have any anxiety or fears

44 If you had any anxieties or fears about your condition or treatment, did a nurse discuss them with you?

- ¹ Yes, completely
- ² Yes, to some extent
- ³ No
- ⁴ I didn't have any anxiety or fears

45 Did you want to be more involved in decisions made about your care and treatment?

- ¹ Yes, definitely
- ² Yes, to some extent
- ³ No

46 Overall, did you feel you were treated with respect and dignity while you were in hospital?

- ¹ Yes, always
- ² Yes, sometimes
- ³ No

47 Overall, how you rate the care you received?

- ¹ Excellent
- ² Very good
- ³ Good
- ⁴ Fair
- ⁵ Poor

48 Would you recommend this hospital to your friends and family?

- ¹ Definitely no
- ² Probably no
- ³ Probably yes
- ⁴ Definitely yes

We are grateful to Picker Institute Europe, Oxford, UK for their permission to use some questions from the Picker Inpatient experience questionnaire in this survey.

SECTION D: ABOUT YOU

49 Gender

- Male
- Female

**50 What was your year of birth
(Please write in) eg 1955**

19

51 Which ward did you spend most of your time on?

52 Overall, how would you rate your health during the past four weeks

- Excellent
- Very Good
- Good
- Fair
- Poor
- Very poor

**53 Do you have any long-standing conditions?
(Tick ALL that apply)**

- Deafness or severe hearing impairment
- Blindness or partially sighted
- A long-standing physical condition
- A mental health condition
- A long-standing illness, such as cancer, HIV, diabetes, chronic heart disease or epilepsy
- Any other long standing condition (please specify)

- No, I do not have a long-standing condition

Then go to section E

**54 Does this condition(s) cause you difficulty with any of the following?
(Tick ALL that apply)**

- Everyday activities that people your age can usually do
- At work, in education, or training
- Access to buildings, streets or vehicles
- Reading or writing
- People's attitudes to you because of your condition
- Communicating, mixing with others, or socialising
- Any other activity (please specify)

- No difficulty with any of these

SECTION E: What is your ethnic origin?

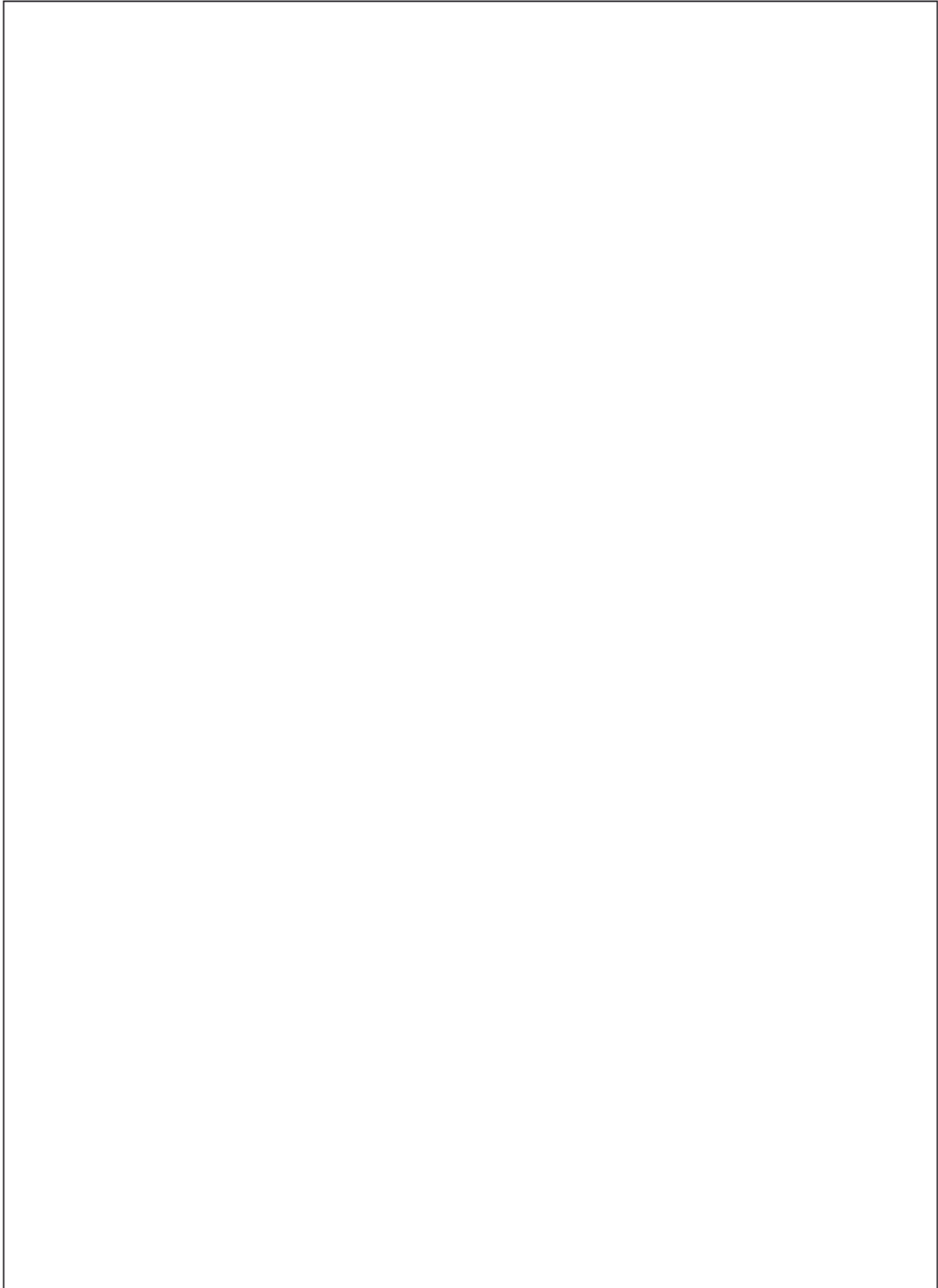
- ¹ White (British/Irish/Any other White background)
- ² Mixed (White and Black Caribbean/White and Black African/White and Asian/Any other mixed background)
- ³ Asian/Asian British(Indian/Pakistani/Bangladeshi/Any other Asian background)
- ⁴ Black/Black British (Caribbean/African/Any other Black background)
- ⁵ Chinese and other ethnic background (Chinese/Other ethnic background)

ANY OTHER COMMENTS

If there is anything else you would like to tell us about your experiences in the hospital, please do so here.

Was there anything particularly good about your hospital stay?**Was there anything that could have been improved?**

Any other comments



NEXT STAGE: WOULD YOU BE WILLING TO TAKE PART?

Over the coming months, we will be inviting patients like you to speak to a member of the research team to tell us more about your experience. It would really help us to know if you would like to take part in the next stage of the research.

Taking part means talking to the researcher face to face or over the telephone one to one. You will be asked to share your views and experiences of being a patient. Anything you say will be confidential, and anonymised once we have spoken to you (your name will not be used).

Agreement to participate now will not be binding in the future and you will be free to withdraw at any stage. You will be able to speak to the researcher for up to an hour at a time and place convenient for you and, with your permission, the conversation will be audio-taped.

- I would be interested in taking part in next phase of the research study
- I am not interested in taking part

If you are interested in taking part or in discussing this further please complete the following details which will help us contact you at a convenient time. This sheet will be detached from your completed questionnaire to ensure your anonymity.

Your name:

Your telephone number:

Your email address:

I would prefer to be contacted by: telephone email either

If you prefer telephone contact, the best times to contact me are:

.....

If you have any questions or queries please do not hesitate to contact Dr Jill Maben on 020 7848 3057 or at jill.2.maben@kcl.ac.uk

THANK YOU VERY MUCH FOR YOUR HELP

Please check that you answered all the questions that apply to you. Please post this questionnaire in the FREEPOST envelope provided to: Dr Jill Maben, National Nursing Research Unit. King's College London FREEPOST. LON1124. London SE1 8YY

Appendix 15 PEECH factor analysis

There was little evidence of researchers attempting to measure the relational aspects of patient care quantitatively in the literature apart from the work of Williams and Kristjanson (2008) (330). These authors developed an instrument (Patient Evaluation of Emotional Care During Hospitalisation - PEECH) which focused on the concept of emotional comfort construct which comprised of three elements: levels of security, knowing and personal value. Markers of security included the ability of staff to display competence, the development of relationships between patients and staff, and availability of staff. Level of knowing hinged on the provision of information to patients. Level of personal value was about both non-verbal and verbal interactions with patients. High levels of these three elements would therefore lead to patients feeling secure, informed and valued.

This theoretical proposition was put to the test using the PEECH survey instrument. The first section contained 19 questions and asked patients what they thought about the staff whom they had contact with during their current admission. Section 2 contained 4 questions asking patients how they felt about their stay in hospital. These 23 questions formed the basis of the hypothesised internal structure: level of security (10 questions), knowing (3) and personal value (10). The last section consisted of 13 questions relating to patient characteristics. A sample of 295 patients were surveyed in a private Australian hospital across ten specialties (cardiology, gynaecology, orthopaedics, maternity, neurosurgery, oncology, aged care, general, ENT, plastic and colorectal surgery) and 132 patients responded. The internal structure arising from the factor analysis is shown in Table 32 below. This supported the theoretical structure that was hypothesised but also identified a new emergent factor that was named level of connection that consisted of two questions Q5 I had the opportunity to get to know the staff as people and Q6 the staff used opportunities to get to know me as a person.

Table 32. Internal structure of Williams and Kristjanson Instrument †

<u>Level of Security</u>	<u>Level of Knowing</u>	<u>Level of personal value</u>	<u>Level of connection</u>
Q1 nurses help	Q9 nurses explain	Q11 staff eye contact	Q5 staff as people
Q2 nurses contact	Q10 doctors explain	Q12 staff distance	Q6 me as a person
Q4 staff competent	Q22 overall informed	Q13 staff voice	(Q3 doctor contact*)
Q7 staff respond		Q14 staff caring	(Q8 staff 24hrs*)
Q20 overall secure		Q15 staff encouraging	
Q21 overall supported		Q16 staff listen	
		Q17 staff expectations	
		Q18 Staff facial expression	
		Q19 Staff conversation	
		Q23 Overall valued	

*Loadings <0.4

†Question descriptions have been abbreviated. The full descriptions can be found above and in Williams and Kristjanson (2008)

The same instrument was used in this study with a small amount of adaption/re-wording for the UK context and for community settings. A decision was taken not to include questions Q3 (Doctor contact) and Q8 (Staff 24 hours) because of their failure previously to load strongly on a single factor and because patients were sent the survey post-discharge. The numbering of the questions was adjusted accordingly although in this section we have retained to original numbering system for ease of comparability. Psychometric testing has been confined to acute settings so that a direct comparison can be made with internal structure found by Williams and Kristjanson. A total of 425 patients from the four acute microsystems (emergency admissions unit, maternity service, department of medicine for the elderly, haematology service) responded giving an overall response rate of 28% (range 23-41%). Nearly all patients who responded answered at least half of the 21 items (99%) and 85% (362) answered all 21 items. A confirmatory factor analysis of the existing structure specifically for ordinal data (utilising polychoric correlations) with oblique (promax) rotation in the presence of missing data (i.e. a patient contributed to the analysis even if they did not respond all questions) was performed using MPLUS v4.2.

Exploratory factor analysis

Most indices indicated a reasonable fit: Comparative Fit Index (range 0-1) 0.93, Tucker Lewis Index (range 0-1) 0.99, Cronbach's alpha 0.82 to .94, but the Root Mean Square Error Approximation (good fit <.05; adequate fit <.08) did not meet the criteria for adequacy. A decision was therefore taken to undertake an exploratory factor analysis (EFA) of the data using MPLUS to ascertain whether this could be attributed to a different internal structure. A summary of the measures of fit produced by the EFA procedure are shown below in Table 33.

Table 33. Exploratory factor analysis

Number of Factors	RMSEA	RMSR	χ^2	Degrees of freedom	$\chi^2/d.f.$
1	0.171	0.087	2538	189	13.43
2	0.118	0.054	1162	169	6.88
3	0.093	0.040	695	150	4.63
4	0.069	0.028	402	132	3.04
5	0.055	0.021	260	115	2.27

RMSEA = Root Mean Square Error Approximation

RMSR = Root Mean Square Residual

The eigenvalue scree plot generated by the EFA suggested that at least two factors were required to describe the underlying structure. The first 3 factors all had eigenvalues greater than 1. The fit indices suggested four or

five factors i.e. adequate fit based on RMSEA and $\chi^2/d.f.$ Drawing on earlier theoretical considerations, a view was taken that four factors provided the best description of the underlying structure. The internal structure that emerged is shown in Table 34 below and shows a divergence from the internal structure found by Williams and Kristjanson (330).

Table 34. Internal structure for the four acute microsystems

Feeling informed	Treated as an individual	Personal interactions	Feeling valued
Q1 nurses help	Q5 staff as people	Q4 staff competent	Q9 nurses explain
Q2 nurses contact	Q6 me as a person	Q11 staff eye contact	Q10 doctors explain
	Q19 staff conversation	Q12 staff distance	Q16 staff listen
		Q13 staff voice	Q17 my expectations of staff
		Q14 staff caring	Q20 overall secure
		Q18 staff facial expression	Q21 overall supported
			Q22 overall informed
			Q23 overall valued

Two questions were not included in the internal structure. All factor loadings for question 7 (staff respond) were less than 0.4 while Q15 staff encouraging loaded on two factors 'Treated as an individual' & 'Personal interactions'.

Mean scores for each of the four factors identified in Table 35 distinguish between high and low performing microsystems as expected.

Table 35. Distinguishing between microsystems – mean factor scores (ranks)

Micro-system	Feeling informed	Treated as an individual	Personal interactions	Feeling valued
Emergency admissions unit	1.93 (4)	1.30 (4)	2.34 (3)	2.13 (4)
Maternity service	2.55 (1)	1.75 (2)	2.53 (2)	2.42 (2)
Medicine for the elderly	1.98 (3)	1.53 (3)	2.21 (4)	2.33 (3)
Haematology service	2.24 (2)	2.10 (1)	2.66 (1)	2.64 (1)
All	2.21	1.66	2.47	2.36

Correlations with the Picker Short-Form index (count of problems as indicated by 15 items) were all in the expected direction i.e. the higher the index the lower the score on each of the four factors; in order of magnitude: Feeling valued (Pearson $r = -0.77$), Personal interactions ($r = -0.62$), Treated as an individual ($r = -0.53$) and Feeling informed ($r = -0.43$). These correlations remained broadly consistent across microsystems. The average mean associations ($\eta = \sqrt{\text{sums of squares between groups/total sums of squares}}$) with Picker overall impression items (Enough nurses on duty, Doctor/nurse teamwork, Wanted to complain, Care received, Would recommend hospital) were also in the expected direction

and in the same order: Feeling valued ($\eta = 0.64$), Personal interactions ($\eta = 0.54$), Treated as an individual ($\eta = 0.45$) and Feeling informed ($\eta = 0.35$).

The degree of divergence between the existing and emergent internal structures is shown in Table 36. The original structure is used as the reference (in columns) and the new factors are indicated by different colours.

Table 36. Comparison of the two internal structures – Factors and items loading under each

Level of security	Level of knowing	Level of personal value	Level of connection
Q1 nurses help Q2 nurses contact	Q9 nurses explain Q10 doctors explain	Q11 staff eye contact Q12 staff distance	Q5 staff as people Q6 me as a person
Q4 staff competent (Q7 staff respond)	Q22 overall informed	Q13 staff voice Q14 staff caring (Q15 staff encouraging)	
Q20 overall secure Q21 overall supported		Q16 staff listen Q17 my expectations of staff Q18 staff facial expression Q19 staff conversation Q23 overall valued	
Feeling informed Treated as an individual			
Personal interactions Feeling valued			

A comparison of measures of fit (Table 37) did not indicate any superiority of one internal structure over the other noting that the confirmatory factor model for this study had the inbuilt advantage of being fitted to the same data that was used in the exploratory factor analysis to identify its internal structure.

Table 37. Comparison of the two internal structures

Measure of Fit	Williams & Kristjanson	Well Being Study
Comparative Fit Index (range 0-1)	0.927	0.952
Tucker-Lewis Index(range 0-1)	0.986	0.989
Root Mean Square Error Approximation	0.131	0.109*
Standardized Root Mean Square Residual	0.061	0.05
Weighted Root Mean Square Residual(WRMSR)	1.664	1.403
WRMSR (in presence of missing data)	1.607	1.251
Cronbach's alpha	(.82 to .94)	(.77 to .94)

*RMSEA lower than in EFA – only items with loadings of 0.4 and above contribute to the fit

In conclusion a different structure to the original instrument emerged. This could be due to a number of reasons; firstly there could be a genuine difference in the relational aspects of patient care found in Australia and the UK. Alternatively the differences could be down to study methodology and the sample. In Australian study the sample covered a far wider range of specialities than in the UK (10 vs. 4) but was much smaller (132 vs. 425). In this study the microsystems were not selected specifically to test the reliability and validity of the instrument but instead to meet the study aims and objectives. At best this is a secondary analysis of data that were collected with another purpose in mind. The instrument was recently tested on a new sample in Australia and a similar structure emerged to that previously found (Williams, 2011, personal communication). Level of connection was scored lower than any other factor in this new Australian sample which resonates with the findings of this study. Two questions is the bare minimum for a factor/sub-scale and additional questions that reflect level of connection/treated as an individual should be sought to improve the robustness of the measure.

For the time being we advise that researchers continue to use Williams and Kristjanson structure in the UK until further testing in a wider range of settings has taken place. Additional developmental work is also required for community settings. In this study we assumed that the instrument could be reasonably applied to community settings accepting that certain questions may had less relevance. Also questions that are pertinent to community settings might have been missing. This is an area worthy of further research given the emphasis being placed on primary care in the government's white paper on health and social care.

Appendix 16 Phase II: Staff interview schedule

1. **Tell me a bit about your job**
description of purpose, responsibilities, priorities; how long you worked here?
2. **What is it like working here? What makes a good shift?**
When you go home at the end of a work day what makes it a good day [bad day]?
Tell me about a recent event that made you feel good [bad] about your job?
Have you ever thought of leaving this job [why]?
[Is this a good place to work compared to other places?]
Tell me about a patient who you enjoyed caring for [didn't enjoy caring for]?
3. **What the main stressors for you at work?**
4. **Do you feel cared for at work?**
What things are happening at work that might improve your life?
Do the people you work with value your work?
How are the people who you work with feeling at the moment?
5. **What do you understand by the phrase 'staff wellbeing'?**
Is your wellbeing important to you?
Is it important in your workplace?
Is it important to your patients? [do patients notice when you are feeling good/ feeling low ?]
6. **Do you think that you can always manage to 'go the extra mile' for patients?**
How do things that happen in your service affect patient experience of care?
How does your own behaviour affect patient experience of care?
How do you manage to draw boundaries between your own and your patients' needs?
How do some patients' and relatives' behaviour towards you affect your feelings and your behaviour at work?
What are the difficult things in caring for patients?
7. **When you have ideas about how to improve services for patients does anyone listen to you?**
Do you consider this part of your work?
Are your efforts appreciated by colleagues, managers or patients?
8. **Is there anything you would like to add?**

Appendix 17 Phase II: Patient interview schedule

1. Tell me about your recent experiences of care
 - What was it like being a patient [in XXX]? (patient journey/examples/ key points of stress; comfort; relief).
 - Is this what you expected [from the service; from other service experiences]?
 - Why do you think these differences in care happen? (keep brief: within/between services).

2. Tell me about your relationships with staff who cared for you
 - How, generally, did staff behave towards you? (probe examples: speech/responses to requests, questions and needs/manner/touch)
 - How did their attitude and behaviour affect your care? (probe experiences of security; how informed they felt; how valued they felt)
 - Do you think that you had to work hard at getting on with [some or all] staff?
 - Did your relationships with staff change over time or did they stay the same during your time in XXX?
 - Describe a member of staff who you especially liked/didn't like? (why?) (probe 'feeling comfortable'; 'connection'; trust; respect; 'listening'; 'extra mile'; 'appropriate' behaviour).
 - Do you think that other patients would agree with you about these staff? (probe examples).
 - Have you seen other patients receiving good care [bad care] (examples).

3. What do you think it is like for staff to work here?
 - What is it like for staff who work here? [probe: how do you know ?]
 - Are there differences in the ways that different staff treat patients? [probe: why].
 - Are there differences in the ways staff treat patients in different parts of the service? [probe: why?]

4. Tell me about some of the 'little things' that staff have done, or have not done, that make it easier or more difficult to be a patient?
 - What do you think is good care? What do you think is bad care? (probe: patient assessments of care/assistance/self-care/communication)

5. Have you had a chance to discuss [or have you been asked about] your experiences of care with anyone from the organisation [service]? [details/ would you have liked to have had such an opportunity]? Was this helpful to you? [if not, why not?]

6. Is there anything you would like to add?

Appendix 18 Example data analysis table – Community Nursing Service - Larchmere

	Effects on Staff (Staff View)	Effects on Patient Care (Staff View)	Effects on Patient Care (Patient View)	Effects on Staff (Patient View)
OUTER CONTEXT				
Introduction of Electronic Patient Record System/'Paper work'	<p>Stressful (system in development; learning new skills; lost/forgotten clinical information)</p> <p>Constant worry: risks of litigation until fully updated; unclear how to record more thoroughly and selectively.</p> <p>Stressful as cannot record accurately <i>some staff were 17 days behind on computerised records.</i></p> <p>Demotivating (time taken from 'real work' of patient care)</p> <p>seen as ineffectual (data sharing between professionals)</p>	<p>Less thorough clinical knowledge of patient on record</p> <p>Less time to spend with patients</p> <p>Increased risk of clinical error due to lost information (notably for nurse prescribers) (602)</p>	<p>2/16 patients note that staff seem to keep a lot of notes but still care for them differently and ask them questions about their care</p>	<p>2 patients identify differences between staff behaviours ('time for them' or 'irritable') caused by amount of paperwork more senior nurse has to do.</p>

	<p>still not possible); expensive; temporary</p> <p>Time consuming: pt assessment can take 3hrs to complete on system. (602)</p> <p><i>F/notes: staff come together as teams promoting patient care over admin;</i></p>			
<p>Community Demographics (1)</p> <p>Stable Population (of staff and patients)</p>	<p>Interesting (opportunity to build relationships with families over time)</p> <p>Reassuring (opportunity to know colleagues as friends)</p> <p>Compromising (when do need to be critical) (626)</p>	<p>Patients know staff by name; like being cared for by people they know; share memories;</p>	<p>Patients note enjoyment of visits by staff they know (socially or previous contact with services)</p>	<p>Staff like living here so happy at work</p>
<p>Community Demographics (2)</p> <p>(variations in income, family networks)</p>	<p>Stimulating (variations in patients' life styles, home circumstances)</p> <p>Frustrating (when they see articulate patients demanding more)</p>			
<p>Recruitment and Training (CNs and DNs)</p> <p>(41630; 41633)</p>	<p>Stress and loss of confidence in junior staff.</p> <p>Caseload holders concerned with litigation</p>	<p>Concerns of all staff with patient safety</p>	<p>1/15 patients note clinical inexperience of junior staff. 4/15 note that feel relaxed and confident with them.</p>	

	<i>Tension in team over how far to support junior qualified staff</i>			
Inter-organisational working	Varies (with attitudes and practices of GPs) Pride : <i>positive recognition of staff (appreciation and care for them) (base 3);</i> 'Biggest stressor' : <i>poor GP referral (unknown complexity/time/physical risks to staff) (602)</i>		Patients positive and defensive of quality of this service (many contrast to GPs and GP receptionists)	
ORGANISATION (2009-EARLY 2010)				
Organisational Ethos	Cynical : staff 'innovation weary'(wary of no-result management agendas) <i>FN: attitude to managers who come to assist them (audit for eg) more positive (also manager who is late without explanation noted).</i>	Innovation agenda and meetings with organisation deducts from front-line patient care (majority of staff); <i>FN : manager late for meeting disrupted home visiting routines/timely care (620)</i>		
Management of mandatory	Demotivating : when poor	Takes time from patient		

training	booking systems; orders to attend (all)	care "patient should come first" (602)		
Workforce Investment (1) Assurance of good staffing levels (no frozen posts)	Relaxed (day to day and longer term planning) Time to organise themselves as a team and for patient care <i>Also: Positive about secondment of 2 staff for DN training this year (all senior staff)</i>			
Workforce Investment (2) varied employment contracts (notably day/night rotas and full/part time)	Convenient (staff can 'work around' needs of family) Exhausting (if lack of recovery time between shifts) Demanding (for other team members because pt staff not always 'up to speed' with changing clinical and social needs) <i>Also Fnotes 3.3.10</i> Disorganising (if the part time staff are senior team members); staff feel poorly informed (609) Marginalising (if staff 'fall	Staff less confident in care of patient; don't know them well	This year " less intimate care ", different faces and less time with me.	

	<p>through gaps' for training and updating) (FNs 19.1)</p> <p>Undermining: pt staff often lack confidence to visit patients who they don't often see</p> <p>Fnotes 3.3.10</p>			
Awards and Recognition	<p>Pride (in service/team): F/Ns recent letters of thanks from Cs and Ps noted by staff; also complaint that pt compliments to CE not forwarded to team</p> <p>'Infectious Practice':</p> <p>Nomination of service carer for award by CN ongoing 'because she's amazing')</p> <p>Cynical: front-line staff don't decide on nominations (managers do)</p> <p>Appreciate organisations' formal recognition of extra effort 'made me really proud of myself' (602)</p>			Is responsibility of organisation to discipline staff if they don't behave well towards me
Work Environment (Physical)	<p>Less stress when available parking; good size rooms (FN: noted in passing, not at interview)</p>	<p>Continuity of care improved when teams share knowledge of patients' clinical and social needs</p>		Staff must feel proud/better in their new building (41034)

	<p>Better working: Teams with GP bases still opt to work in shared locality (shared working; sociable) even though overcrowded.</p> <p>Vulnerability of out-of-hours working (conversations about empty bases/buildings rather than visiting homes)</p>			
Inter-service Working	<p>Less frustrating if personal (as able to 'have a chat' with some known staff directly and 'get things moving'); eased when share accommodation or offices (eg CM and CNs base 3)</p> <p>Pride at co-operative working with some GPs : FN: some clinic responsibilities temporarily not discharged to GP</p>	<p>'Patients cannot be turned away'</p>		
Service Referral System	<p>Recognition (professional autonomy) of staff as they manage referrals (no SPoR).</p> <p>Staff all seem to enjoy patients they know calling</p>	<p>Patients reassured by knowing that staff can be called any time and 'are only just down the road'</p> <p>During visits staff regularly</p>	<p>All patients value the accessibility of staff they know</p> <p>FN: (one complaint by relative about mobile</p>	

	<i>them to check on visit times/clinical conditions (not seen as an intrusion but part of care)</i>	<i>remind patients to/how to contact them if worried</i>	<i>switched off for 2 hours and unable to contact)</i>	
Specialist skills training	Pride (especially when noted in service magazine)	Good for patients (care in community and with known staff); reduces stress of cancelled appointments		
Student training/Placement	Positive Recognition of staff (as individuals and team) <i>Students/team exchange goodbye gifts.</i>	Seen as interesting for patients to 'see new faces' (603)		
Locality Management				
Engaged clinical leadership (also offers cover)	Appreciated: recognition of the nature of their work and as helpful to them.			
Clinical leader who is former colleague	Reassuring: can take a problem to him and he 'knows what you mean' Relaxed: he knows workload variations); 'takes a joke' Uncertain: (Sometimes) feel poorly led as this person not well experienced and too socially involved.			

	<i>FN: Clinical lead recognises and voices common staff complaints ('over innovation', 'lack of recognition' 'business') to them</i>			
Lead who (does not step back) guides less experienced staff to meet organisational mandates (eg. training)	Feels less 'us and them', makes everything easier for working (41609)			
Clinical supervision	Reassuring for newly qualified (learning and 'ally') Resisted by all other staff (seen as informal and sufficient)	Patient safety (concern with newly qualified only)		
Team				
Handovers/meetings/organisation of workload	Relaxed, time, staff asked if 'would mind') <i>40-60 mins for arranging care of up to 25 patients</i> <i>Staff 'check' and offer/receive help on daily basis; Not unusual for sometimes use own time for meetings</i>	Patients often call in during this time to ask questions about visits or clinical changes. All advised by staff who know them personally		
Staffing (numbers, skill	<i>FN: rarely mentioned as issue</i>	<i>Focus Group team 3:</i>		

mix)	<p>in 2 teams and key issue in 3rd (colours all views of organisational support)</p> <p>Disappointment: 3rd team note that unable to use new specialist skills because too short staffed</p>	<p>Staff 'work together' so well that they cover patient needs despite staff shortages (however this base has more odd sick days recurring chronic illness).</p> <p>Patient education for independence affected (eg. bladder care education)</p>		
Accessible, approachable lead (keep confidences)	<p>Reassured: feel clinically supported and have 'safety net' in difficult times</p>			
Team(s) protective in difficult times (eg incident) (601;609)	<p>Reassured and supported</p> <p>FN: Always positive about one another.</p> <p>FN: Movement of senior staff between teams for induction/cover</p>	<p>FN: all staff also positive about patients (in general; 'matra' of lovely patients used by all staff.</p>		
Senior staff who trust you at work (who don't 'check up on you') (627;611;612)	<p>respected and confident in their work</p> <p>Stressed because 'singled out' by case manager (FN 9.9.10)</p>			

Senior colleagues who will do the same work as you (if necessary) (627)	Feel that you and your work are valued			
Motivated, clinically confident and relaxed senior colleagues (601;610;618;627)	Reassuring: feel clinically supported and not stressed during difficult times.			2 patients note the differences between staff in team who are junior/inexperienced/stressed and those who are not
All team members capable (skilled and not tired at work) (609;623)	Feel fairly treated: workload and work responsibilities are equitable			
Tone of voice when phone in sick	The reception/tone of voice you get when call in sick (implies 'if others can do it') (41610)			
Demanding care work (eg. terminal care; difficult patient) shared across team (601;623)	Reduced distress/stress of patient care <i>Humour of difficult/ridiculous patient or family also shared (FNs)</i>			
Health care professionals and assistants' appreciation of other team roles	Unfair when admin work not understood or valued (41610)			

Senior staff work with junior colleagues(608)	Appreciate opportunities for clinical learning			
Leaders and colleagues who are flexible with rotas when really needed (627)	Appreciate that people understand what is going on at home/will make life easier			
Colleagues who make it possible to take back time owed (611)	Don't feel guilty about taking what you are owed			
Colleagues who work at making or protecting friendships at work (623); no 'backbiting'. Positive efforts to make a team (team events and personal lives)	Makes you feel that you want to be at work (609) <i>F/n: staff positive about each other in meetings/discussions</i> <i>F.N 1.3.10: difficult for staff to be critical of routines or innovations as 'upsetting'; boundary between prof life and social life very fine.</i>			
Nature of Work				
Autonomy in planning care priorities/direct care (between patients and case load) (618; 602;601)	Enjoy responsibility Stressed when patient care/case load demands become too great			Visiting times (reliability) varies between staff

(see * 'Individual' below)	Some home care responsibilities stressful (eg. control drugs) (602;614)			
Emotional Work	'Take work home' when dealing with deaths at night (few staff involved and lonely time) (609) Growing attached to/listening to patients, 'go in [patient's home] cheerful and come our exhausted' (609)	Patients prefer to die at home with people and nurses they know Good for patients to talk because some 'don't have anyone else'	'Staff who are friends' noted by majority of longstanding patients/carers.	Patient's aren't easy People 'let fly' when ill
Clinical Care	Satisfying work: to see that you have healed a wound; organised palliative care for 'good death' (602) So relies on continuous involvement in care	Patients appreciate you and less in pain (602)		2 patients note variations in quality of clinical care in relation to how many other patients have to be seen that day Frustrating when wounds don't heal
STAFF/PATIENT RELATIONS				
Doing the 'little extras' of patient care/home visit (623) <i>FN: all staff initiate</i>	Recognition by patient family/colleagues important Co-ordination of some services is seen as 'extra' for	Patient benefits clinically as well as emotionally from better co-ordinated care (601) Also 'nice patient' so you	Key aspects, eg care co-ordination, organisation of meds, seen as a personal 'favour' (makes life easier).	

<p><i>interagency working/care coordination if they think it's required.</i></p>	<p><i>CN and DN staff, staff note enjoyment of this work (enjoy it if 'patient lovely') FN: Recognition by colleagues important</i></p> <p>Worry that some 'extra things' might make patient more sick (602)</p> <p>Resent patients who then draw them into complaints/investigations over other care services</p>	<p>don't mind (repeated often by staff)</p>		
<p>Visiting known patients/families (not necessarily the 'easiest' patients) (all)</p>	<p>Enjoy 'chatting', 'cheering someone up', 'having a laugh' (all)</p> <p>Visiting patients you know is relief from office/team pressures (613)</p> <p><i>F/notes 1.3.10: 'knowing a patient' is clinical, social and personal history, daily routines, expressions (pain), sense of humour, rhythm of clinical intervention</i></p> <p><i>F/notes 1.3.10:co-ordination(advice, calls) of services 'flows' from this knowledge (not separate job)</i></p>	<p>All patients will value this (all staff)</p>	<p>Don't like 'different faces every day'.</p> <p><i>FN (4): older patients often confuse staff (many staff ignore this); other patients visited by staff they know better are very different (talk, inquire, confide)</i></p> <p><i>FN: 11.2.09</i></p> <p><i>In domiciliary setting patients sometimes unaware of the norm/of what is 'extra' or a compromise unless staff</i></p>	

		<p><i>FNs: 11.2.09</i></p> <p><i>For ('known' 'special') patients to be able to manage staff adapt norms and routines eg. smoking; lifting; fetching ect.</i></p> <p><i>(extra things are highly personalised)</i></p>	<p><i>remind them (which these staff don't); other times offer gifts to team</i></p>	
Investment in Patients by Team	<p>Frustrating (for band 6) when conversations about patients overshadows completion of clinical management tasks (626)</p> <p>Enjoyment of patients (key part of job but, with some patients, is more than a job) (624)</p>	<p>Less effective care co-ordination (626)</p>		
Investment in Town/Locality	<p>Enjoy being 'known' and recognised in street (624)</p>			
To be known as a special individual by patient/family (623:)	<p>Rewarding to be recognised; to 'feel special' or that have made a special contribution to care</p>	<p>Patients and staff like to show gratitude</p> <p><i>(Fn:1.3.10 time spent with</i></p>	<p>Many patients value mutual aspects of care (offer small favours); 'working together'</p>	<p>Staff know patients so makes job rewarding</p>

	<p>Pride in ability to 'charm', 'talk patients around', manage difficult situations when colleagues cannot (625;602)/shame of staff who 'wind up patients'</p> <p>Upsetting when patients complain about your behaviour to colleagues or managers without your knowledge (breach of trust)</p> <p>FN: Worry about welfare of carers during terminal care (602)</p>	<p>pt/former carer (5mins) helped her to grieve for her husband</p>	<p>FN: easier for patients to converse informally with known staff (to ask questions, recognise the individual)</p>	
<p>Home visits/home visits with sufficient time for patient-centred care (601;602;609;623)</p>	<p>Pleasure in spending time 'as guest' in patients home; getting to know patient there; enjoying 'view' of different life.</p> <p>Difficulty in managing the competing demands of this care; clinical care although refusal, confusion FNs (19.1.09)</p>			<p>Staff feel vulnerable in patient's homes</p> <p>Access to homes sometimes difficult</p>
<p>Dealing (alone) with Patient/Family Distress or felt aggression</p>	<p>Upsetting; wearing (610)</p> <p>Rewarding when 'settle patient/family' down (a skill!)</p>			

	(602;614) <i>FNs</i> <i>FNotes (1) Can also involve knowledge of available services (more senior staff can manage this)</i>			
Getting blame for effects of poor care systems (eg. hospital discharge; GO referrals) (611;)	Feel unfairness but try to see and discuss patients' position (some see as enjoyable challenge) (602;614) Stress: at being unable to manage poor services (discharge; GP; personal care).	Frustrated because of the situation (pain, fear) or because have received poor services/referral (eg from GP) Patients don't notice the work that you do to make their care possible (602)	<i>FNs: Often confusion about services (personal care, specialist care, DNs, practice nurses); also experience of care coloured by one (sometimes indirect care event) (easier when named staff)</i>	
Some patients demanding more (home visits) than they need (611;623)	Irritating. Reminds staff that clinical judgement secondary to politics of care (risks of formal complaint)			
Getting to know some patients (all staff)	Amusing; fascinating; humbling <i>Band 6 notes that 'the ooh factor can distract from clinical work and organisation</i>			
INDIVIDUAL FACTORS				
Home context	Relieved/supported when 'can go home to someone who			2 patients aware of home difficulties of 2 staff and

(609; 611;)	listens'			'don't go there'
Work life/home life	<p>Less stressful and tiring when work close to home; when working with people you know (all staff)</p> <p>Leave (rare) because want to specialise; only work weekdays (601)</p>			3 patients note one staff member who seems 'overburdened', with work responsibilities
Personal history (609;601;611)	<p>Motivating when feel able to use personal experiences to support patient/family</p> <p>Distressing when personal and patient/family suffering 'too close' (eg. grief, disability) (613); however some staff able to use experience empathically "I know how she feels" (613) and resignation that "do the best you can"</p>	More likely to help patient/family when less involved and know limits of what possible (602;613)		

Employment history (602;605;604;634)	Satisfying work (less pay) than previous factory work; More relaxed, rewarding, than acute; Less stressful than paed; more patient contact/recognition than acute; more autonomy than acute (answer to medical hierarchy).			
'Person Skills' (602;614;612)	Past experience or personality means that able to deal with challenging patients (and be take pride in this)			
Chronic Illness (609;601)	Poor health when sickness time not taken for ongoing illness/injury due to obligations to team	Doesn't affect patients, 'don't let it show' (609).		

Appendix 19 Patient survey respondents

This appendix gives details of the patient profile, and includes tables detailing patient age, gender, health, long term conditions by microsystem.

Table 38. Patient age

Age-band	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
<20	No.	4	7	0	5	0	0	0	0	16
	%	2.5%	5.0%	.0%	5.0%	.0%	.0%	.0%	.0%	3.2%
20-29	No.	15	70	0	4	0	0	1	0	90
	%	9.4%	50.4%	.0%	4.0%	.0%	.0%	2.9%	.0%	18.1%
30-39	No.	19	55	0	5	0	0	1	0	80
	%	11.9%	39.6%	.0%	5.0%	.0%	.0%	2.9%	.0%	16.1%
40-49	No.	17	7	0	15	1	1	1	0	42
	%	10.7%	5.0%	.0%	14.9%	10.0%	6.3%	2.9%	.0%	8.4%
50-59	No.	26	0	0	19	0	2	3	1	51
	%	16.4%	.0%	.0%	18.8%	.0%	12.5%	8.8%	7.7%	10.2%
60-69	No.	33	0	0	24	0	3	8	0	68
	%	20.8%	.0%	.0%	23.8%	.0%	18.8%	23.5%	.0%	13.7%
70-79	No.	23	0	4	15	3	2	11	2	60
	%	14.5%	.0%	15.4%	14.9%	30.0%	12.5%	32.4%	15.4%	12.0%
80-89	No.	14	0	19	11	5	5	7	6	67
	%	8.8%	.0%	73.1%	10.9%	50.0%	31.3%	20.6%	46.2%	13.5%
90-99	No.	4	0	3	1	1	2	2	4	17
	%	2.5%	.0%	11.5%	1.0%	10.0%	12.5%	5.9%	30.8%	3.4%
100+	No.	1	0	0	0	0	1	0	0	2
	%	.6%	.0%	.0%	.0%	.0%	6.3%	.0%	.0%	.4%
Not answered	No.	3	0	0	2	0	0	0	0	5
	%	1.9%	.0%	.0%	2.0%	.0%	.0%	.0%	.0%	1.0%
Total	No.	159	139	26	101	10	16	34	13	498
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The age profile of patients was older for community microsystems and for medicine for the elderly. As expected maternity patients were the youngest (Table 38).

Table 39. Patient gender

Gender	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
Male	No.	55	0	10	55	4	5	15	3	148
	%	34.6%	.0%	38.5%	54.5%	40.0%	31.3%	44.1%	23.1%	29.7%
Female	No.	99	137	16	45	6	11	18	10	342
	%	62.3%	98.6%	61.5%	44.6%	60.0%	68.8%	52.9%	76.9%	68.7%
Not answered	No.	5	2	0	1	0	0	1	0	8
	%	3.1%	1.4%	.0%	1.0%	.0%	.0%	2.9%	.0%	1.6%
Total	No.	159	139	26	101	10	16	34	13	498
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Haematology was the only microsystem where the proportion of males was higher than females. Apart from Maternity the highest proportion of females was found amongst patients seen by the rapid response team. This microsystem also had the oldest patient profile (Table 39).

Table 40. How did patients rate their health?

Overall, how would you rate your health during the past four weeks?	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
Excellent	No.	5	27	0	4	0	0	2	1	39
	%	3.1%	19.4%	.0%	4.0%	.0%	.0%	5.9%	7.7%	7.8%
Very good	No.	28	58	3	18	1	1	6	2	117
	%	17.6%	41.7%	11.5%	17.8%	10.0%	6.3%	17.6%	15.4%	23.5%
Good	No.	34	37	11	29	2	4	10	5	132
	%	21.4%	26.6%	42.3%	28.7%	20.0%	25.0%	29.4%	38.5%	26.5%
Fair	No.	51	12	9	36	5	4	9	3	129
	%	32.1%	8.6%	34.6%	35.6%	50.0%	25.0%	26.5%	23.1%	25.9%
Poor	No.	31	5	3	9	2	7	6	2	65
	%	19.5%	3.6%	11.5%	8.9%	20.0%	43.8%	17.6%	15.4%	13.1%
Very poor	No.	5	0	0	2	0	0	0	0	7
	%	3.1%	.0%	.0%	2.0%	.0%	.0%	.0%	.0%	1.4%
Not answered	No.	5	0	0	3	0	0	1	0	8
	%	3.1%	.0%	.0%	1.6%	.0%	.0%	2.9%	.0%	1.6%
Total	No.	159	139	26	101	10	16	34	13	498
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Maternity patients not surprisingly rated their health more highly than patients in any other microsystem (Table 40). The Community Matron Service provided care to patients who were in the poorest health.

Table 41. Patient's longstanding conditions

Long-standing conditions	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
Deafness or severe hearing impairment	No. 17	1	1	10	2	5	3	4	43	
	% 11.3%	.7%	3.8%	10.1%	20.0%	31.3%	9.4%	33.3%	8.9%	
Blindness or partially sighted	No. 3	1	3	1	1	4	2	1	16	
	% 2.0%	.7%	11.5%	1.0%	10.0%	25.0%	6.3%	8.3%	3.3%	
A long-standing physical condition	No. 33	2	7	5	2	6	10	4	69	
	% 21.9%	1.5%	26.9%	5.1%	20.0%	37.5%	31.3%	33.3%	14.3%	
A mental health condition	No. 5	3	2	3	0	2	1	0	16	
	% 3.3%	2.2%	7.7%	3.0%	.0%	12.5%	3.1%	.0%	3.3%	
A long-standing illness, such as cancer, HIV, diabetes, CHD or epilepsy	No. 40	3	7	63	2	9	10	1	135	
	% 26.5%	2.2%	26.9%	63.6%	20.0%	56.3%	31.3%	8.3%	28.0%	
Any other long standing condition	No. 52	13	9	28	4	9	14	7	136	
	% 34.4%	9.5%	34.6%	28.3%	40.0%	56.3%	43.8%	58.3%	28.2%	
No, I do not have a long-standing condition	No. 48	120	9	12	0	0	6	1	196	
	% 31.8%	87.6%	34.6%	12.1%	.0%	.0%	18.8%	8.3%	40.6%	
All who responded to one or more items	No. 151	137	26	99	10	16	32	12	483	

Many of the patients (80% or higher) seen by the community microsystems and haematology had long-term conditions. Maternity patients were least likely to have long-term conditions (Table 41).

Table 42. Do long-term conditions cause difficulties?

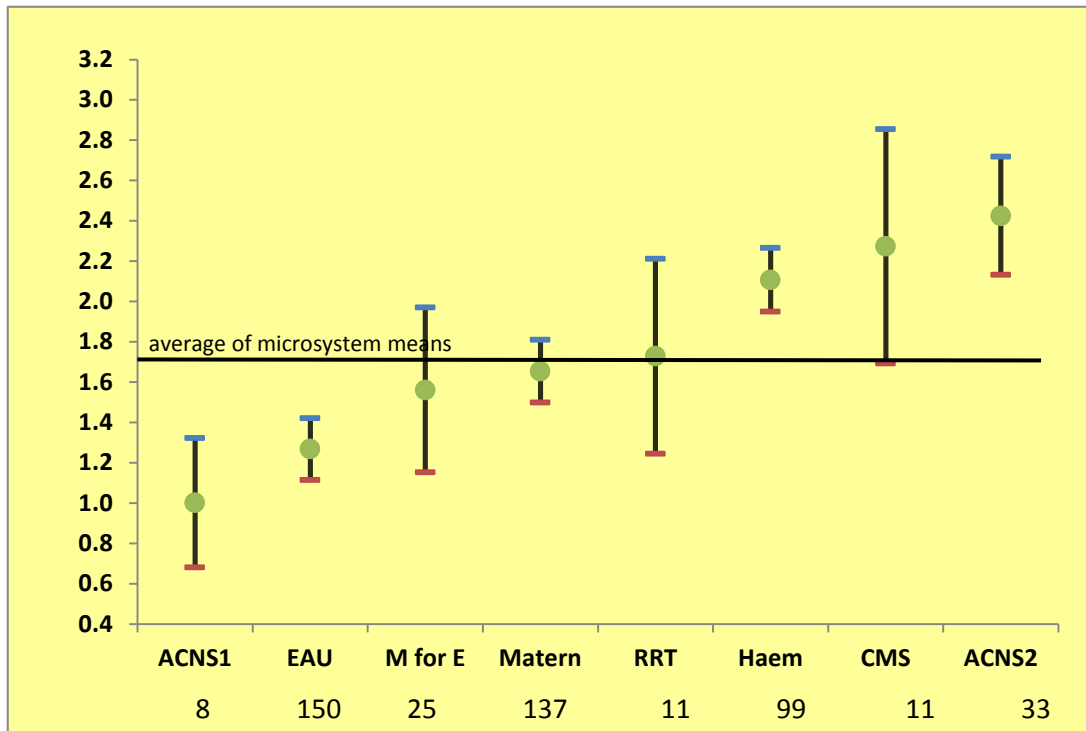
Does this condition cause you difficulties with:	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
Everyday activities that people your age can usually do	No. 63	7	10	38	8	10	17	4	157	
	% 57.3%	28.0%	58.8%	44.7%	88.9%	66.7%	56.7%	33.3%	51.8%	
At work, in education, or training	No. 20	3	1	22	1	2	6	3	58	
	% 18.2%	12.0%	5.9%	25.9%	11.1%	13.3%	20.0%	25.0%	19.1%	
Access to buildings, streets or vehicles	No. 21	3	8	8	7	11	12	6	76	
	% 19.1%	12.0%	47.1%	9.4%	77.8%	73.3%	40.0%	50.0%	25.1%	
Reading or writing	No. 9	1	5	4	2	6	2	4	33	
	% 8.2%	4.0%	29.4%	4.7%	22.2%	40.0%	6.7%	33.3%	10.9%	
Peoples attitudes to you because of your condition	No. 17	5	1	9	2	4	4	3	45	
	% 15.5%	20.0%	5.9%	10.6%	22.2%	26.7%	13.3%	25.0%	14.9%	
Communicating, mixing with others, or socialising	No. 23	4	2	11	6	6	7	4	63	
	% 20.9%	16.0%	11.8%	12.9%	66.7%	40.0%	23.3%	33.3%	20.8%	
Any other activity	No. 17	1	7	16	0	5	9	3	58	
	% 15.5%	4.0%	41.2%	18.8%	.0%	33.3%	30.0%	25.0%	19.1%	
No difficulty with any of these	No. 35	17	3	30	0	3	6	2	96	
	% 31.8%	68.0%	17.6%	35.3%	.0%	20.0%	20.0%	16.7%	31.7%	
All who responded to one or more items	No. 110	25	17	85	9	15	30	12	303	

Patients seen by the first community nursing service were all experiencing difficulties due to long-term conditions (Table 42). Overall the community

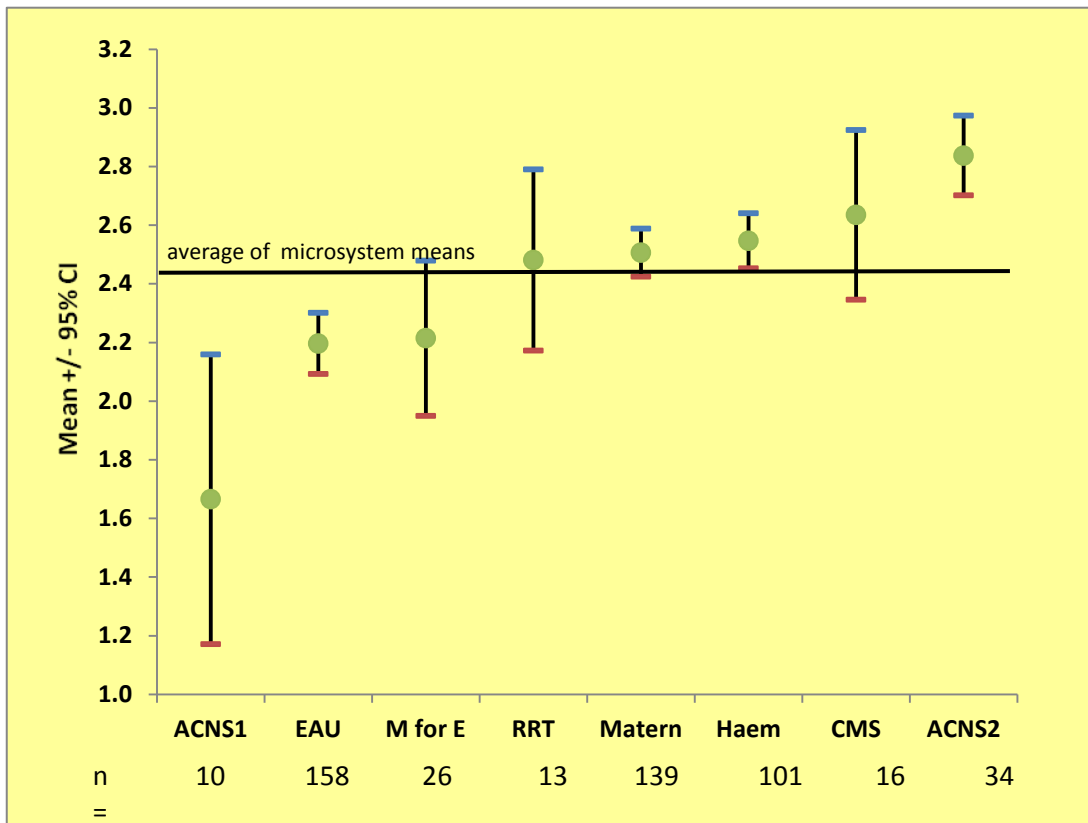
services were more likely to provide care to patients experiencing difficulties. This was also evident for medicine for the elderly.

Appendix 20 PEECH survey results by 'level' including confidence intervals

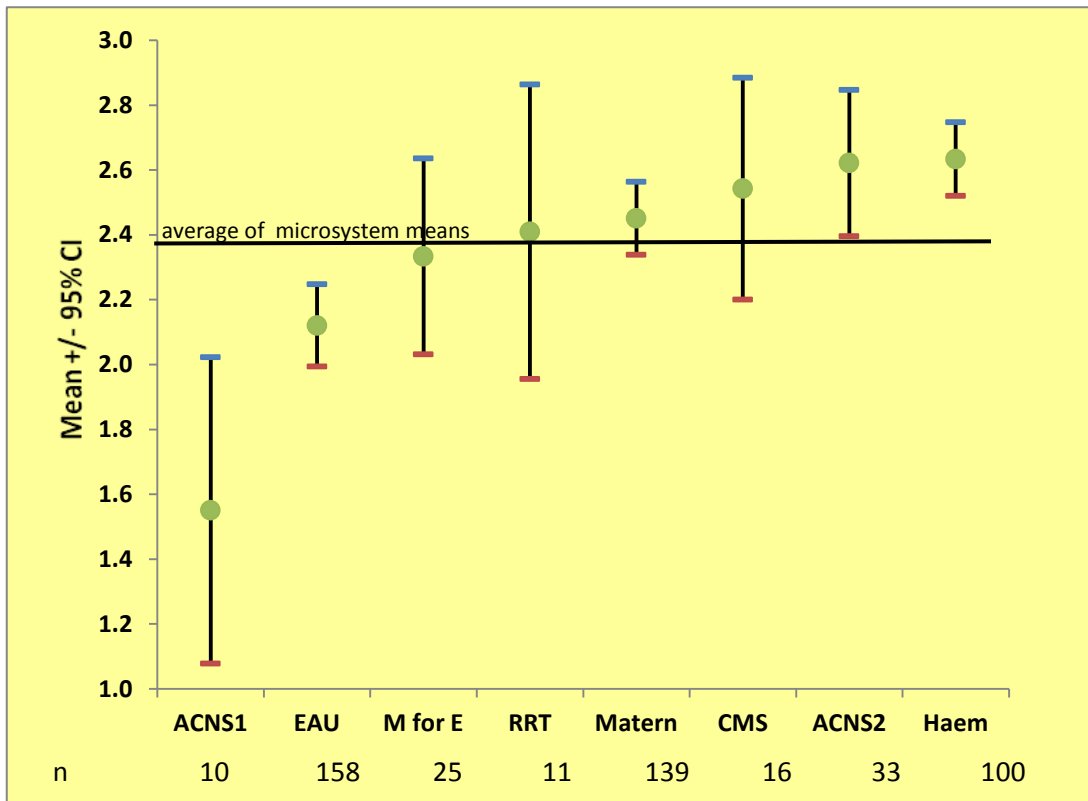
Level of Connection



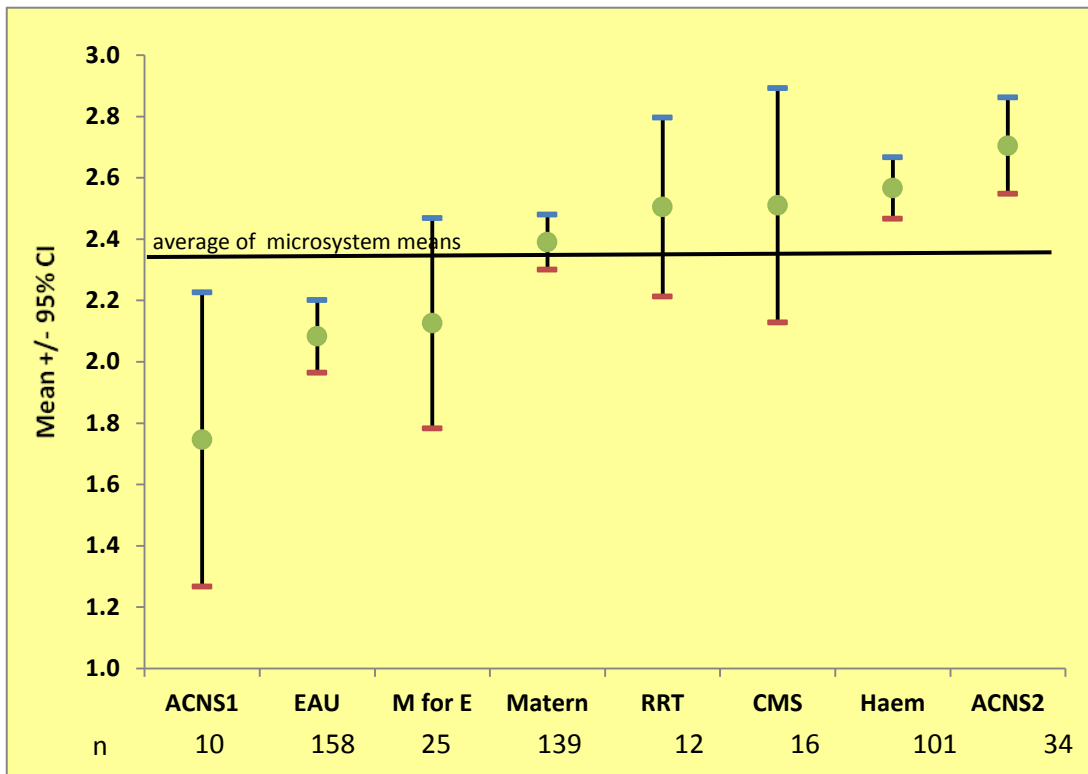
Level of Security



Level of Knowing



Level of Personal Value



Appendix 21 Staff survey respondents' profile

This appendix gives details of the staff profile, and includes tables detailing staff gender, age, ethnicity, years of working in the same Trust, several questions relating to teamworking, occupational group and highest level of educational qualification.

Table 43. Gender

Gender	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
Male	No. 2	0	21	1	4	0	0	2	30	
	% 4.4%	.0%	31.8%	6.3%	13.8%	.0%	.0%	6.5%	10.0%	
Female	No. 33	79	38	14	22	8	27	26	247	
	% 73.3%	100.0%	57.6%	87.5%	75.9%	100.0%	100.0%	83.9%	82.1%	
No answer	No. 10	0	7	1	3	0	0	3	24	
	% 22.2%	.0%	10.6%	6.3%	10.3%	.0%	.0%	9.7%	8.0%	
Total	No. 45	79	66	16	29	8	27	31	301	
	% 100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Medicine for the elderly was the only microsystem where there was a relatively high proportion of male staff (32% vs. 4% for all the other microsystems) (Table 43).

Table 44. Age

Age-group	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
21-30	No. 8	14	10	5	1	0	3	7	48	
	% 17.8%	17.7%	15.2%	31.3%	3.4%	.0%	11.1%	22.6%	15.9%	
31-40	No. 8	7	14	3	0	2	3	9	46	
	% 17.8%	8.9%	21.2%	18.8%	.0%	25.0%	11.1%	29.0%	15.3%	
41-50	No. 9	30	6	3	16	4	11	8	87	
	% 20.0%	38.0%	9.1%	18.8%	55.2%	50.0%	40.7%	25.8%	28.9%	
51-65	No. 6	10	6	2	6	1	5	4	40	
	% 13.3%	12.7%	9.1%	12.5%	20.7%	12.5%	18.5%	12.9%	13.3%	
No answer	No. 14	18	30	3	6	1	5	3	80	
	% 31.1%	22.8%	45.5%	18.8%	20.7%	12.5%	18.5%	9.7%	26.6%	
Total	No. 45	79	66	16	29	8	27	31	301	
	% 100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Staff working in the acute microsystems were generally younger; with the exception of staff in maternity, than staff working in the community (Table 44). Staff working for the rapid response team had the youngest mix of staff of the four community microsystems.

Table 45. Ethnicity

Ethnic Group	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
White	No. 43	75	51	16	16	5	27	23	256	
	% 95.6%	94.9%	77.3%	100.0%	55.2%	62.5%	100.0%	74.2%	85.0%	
Mixed	No. 2	0	2	0	2	0	0	1	7	
	% 4.4%	.0%	3.0%	.0%	6.9%	.0%	.0%	3.2%	2.3%	
Asian/ Asian	No. 0	0	6	0	2	0	0	5	13	
British	% .0%	.0%	9.1%	.0%	6.9%	.0%	.0%	16.1%	4.3%	
Black/ Black	No. 0	0	2	0	9	3	0	1	15	
British	% .0%	.0%	3.0%	.0%	31.0%	37.5%	.0%	3.2%	5.0%	
Chinese and	No. 0	1	3	0	0	0	0	0	4	
other	% .0%	1.3%	4.5%	.0%	.0%	.0%	.0%	.0%	1.3%	
No answer	No. 0	3	2	0	0	0	0	1	6	
	% .0%	3.8%	3.0%	.0%	.0%	.0%	.0%	3.2%	2.0%	
Total	No. 45	79	66	16	29	8	27	31	301	
	% 100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Fewer staff working in the acute microsystems were from the ethnic minorities; the one exception was medicine for the elderly (20%) (Table 45). Conversely the community microsystems had a higher proportion of staff from the ethnic minorities; the exception was the second adult community service. All staff working in this service were from a white background.

Table 46. Years of working in the same trust

Years worked for the trust	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
Less than one year	No. 4	3	9	4	6	0	3	4	33	
	% 8.9%	3.8%	13.6%	25.0%	20.7%	.0%	11.1%	12.9%	11.0%	
1-2 years	No. 7	5	21	5	5	0	2	5	50	
	% 15.6%	6.3%	31.8%	31.3%	17.2%	.0%	7.4%	16.1%	16.6%	
3-5 years	No. 4	19	7	1	7	7	2	11	58	
	% 8.9%	24.1%	10.6%	6.3%	24.1%	87.5%	7.4%	35.5%	19.3%	
6-10 years	No. 16	6	13	2	2	0	6	7	52	
	% 35.6%	7.6%	19.7%	12.5%	6.9%	.0%	22.2%	22.6%	17.3%	
11-15 years	No. 5	12	7	3	3	0	3	3	36	
	% 11.1%	15.2%	10.6%	18.8%	10.3%	.0%	11.1%	9.7%	12.0%	
More than 15 years	No. 9	34	9	1	6	1	10	1	71	
	% 20.0%	43.0%	13.6%	6.3%	20.7%	12.5%	37.0%	3.2%	23.6%	
No answer	No. 0	0	0	0	0	0	1	0	1	
	% .0%	.0%	.0%	.0%	.0%	.0%	3.7%	.0%	.3%	
Total	No. 45	79	66	16	29	8	27	31	301	
	% 100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

The number of years that staff had worked in the trust varied considerably across the microsystem with no discernible pattern although some of distributions of staff could be explained by the nature of the service (Table 46). For example there was a high proportion of staff working in the maternity microsystem with over 16 years of service and may reflect national shortages and insufficient new midwives entering the profession to meet demand. Conversely the all community matrons apart from one had been working for less than six years in the trust and relates to the introduction of matron posts during the middle of the last decade. The two adult community nursing services were contrasting. The numbers of years

worked by staff in first service (ACNS1) was quite varied with six staff (21%) in place for less than a year whereas in the second service (ACNS2) over a third of staff had been working for 16 or more years in the same trust. A relatively high proportion of staff had worked less than 3 years in the same trust in the haematology and medicine for the elderly microsystems compared with the two other acute microsystems (56%, 45% vs. 24%, 10%).

Table 47. Do you manage staff within the trust?

Manage staff in trust		Micro-system								Total
		EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT	
Yes	No.	12	16	23	7	10	5	9	7	89
	%	26.7%	20.3%	34.8%	43.8%	34.5%	62.5%	33.3%	22.6%	29.6%
No	No.	33	62	39	9	16	3	17	19	198
	%	73.3%	78.5%	59.1%	56.3%	55.2%	37.5%	63.0%	61.3%	65.8%
No answer	No.	0	1	4	0	3	0	1	5	14
	%	.0%	1.3%	6.1%	.0%	10.3%	.0%	3.7%	16.1%	4.7%
Total	No.	45	79	66	16	29	8	27	31	301
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The level of management responsibility varied across microsystems (Table 47). The highest levels were reported by staff working in the community matron service (63%) and haematology (44%) and lowest levels in maternity (20%) and the rapid repose team (23%).

Table 48. Do you work in a team?

Work in a team		Micro-system								Total
		EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT	
Yes	No.	44	74	64	16	29	8	27	30	292
	%	97.8%	93.7%	97.0%	100.0%	100.0%	100.0%	100.0%	96.8%	97.0%
No	No.	1	5	2	0	0	0	0	0	8
	%	2.2%	6.3%	3.0%	.0%	.0%	.0%	.0%	.0%	2.7%
No answer	No.	0	0	0	0	0	0	0	1	1
	%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	3.2%	.3%
Total	No.	45	79	66	16	29	8	27	31	301
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Nearly all staff said they were part of a team. A small number of staff working in the maternity unit said they were not (6%) (Table 48).

Table 49. Do you have face-to-face contact with patient/service users as part of your job?

Face-to-face contact with patients		Micro-system								Total
		EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT	
Yes frequently	No.	44	71	61	13	24	7	24	28	272
	%	97.8%	89.9%	92.4%	81.3%	82.8%	87.5%	88.9%	90.3%	90.4%
Yes occasionally	No.	0	6	4	1	4	0	1	1	17
	%	.0%	7.6%	6.1%	6.3%	13.8%	.0%	3.7%	3.2%	5.6%
No	No.	0	0	1	1	1	0	0	1	4
	%	.0%	.0%	1.5%	6.3%	3.4%	.0%	.0%	3.2%	1.3%
No answer	No.	1	2	0	1	0	1	2	1	8
	%	2.2%	2.5%	.0%	6.3%	.0%	12.5%	7.4%	3.2%	2.7%
Total	No.	45	79	66	16	29	8	27	31	301
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Most staff across the eight microsystems had face-to-face contact with patients (96%) (Table 49). The first adult community nursing service had the highest proportion of staff that either saw patients occasionally or not at all (17%).

Table 50. Does your team have clear objectives?

Work closely to achieve team		Micro-system								Total
		EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT	
Yes	No.	39	67	57	15	18	7	24	26	253
	%	86.7%	84.8%	86.4%	93.8%	62.1%	87.5%	88.9%	83.9%	84.1%
No	No.	5	5	8	1	11	1	3	5	39
	%	11.1%	6.3%	12.1%	6.3%	37.9%	12.5%	11.1%	16.1%	13.0%
No answer	No.	1	7	1	0	0	0	0	0	9
	%	2.2%	8.9%	1.5%	.0%	.0%	.0%	.0%	.0%	3.0%
Total	No.	45	79	66	16	29	8	27	31	301
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Most staff said they worked in teams that operated to clear objectives; the one exception was the first adult community nursing service where 38% of staff stated that this was not the case (Table 50).

Table 51. Do you have to work closely with other team members to achieve the team's objective?

Work closely to achieve objectives		Micro-system								Total
		EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT	
Yes	No.	40	69	60	15	21	8	26	30	269
	%	88.9%	87.3%	90.9%	93.8%	72.4%	100.0%	96.3%	96.8%	89.4%
No	No.	5	2	5	1	6	0	1	1	21
	%	11.1%	2.5%	7.6%	6.3%	20.7%	.0%	3.7%	3.2%	7.0%
No answer	No.	0	8	1	0	2	0	0	0	11
	%	.0%	10.1%	1.5%	.0%	6.9%	.0%	.0%	.0%	3.7%
Total	No.	45	79	66	16	29	8	27	31	301
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Most staff said they had to work closely with other team members to achieve the team's objective; the one exception was the first adult community nursing service where 21% of staff stated that this was not the

case (Table 51). This also applied to a small number of staff in the Emergency Admissions Unit (11%).

Table 52. Does the team meet regularly and discuss its effectiveness and how it could be improved?

Team meets regularly		Micro-system								Total
		EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT	
Yes	No.	15	56	44	10	17	6	22	28	198
	%	33.3%	70.9%	66.7%	62.5%	58.6%	75.0%	81.5%	90.3%	65.8%
No	No.	30	15	20	6	12	1	5	3	92
	%	66.7%	19.0%	30.3%	37.5%	41.4%	12.5%	18.5%	9.7%	30.6%
No answer	No.	0	8	2	0	0	1	0	0	11
	%	.0%	10.1%	3.0%	.0%	.0%	12.5%	.0%	.0%	3.7%
	No.	45	79	66	16	29	8	27	31	301
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The proportion of staff who met as a team to discuss effectiveness and improvements varied much more considerably than the previous two elements of teamwork (Table 52). On the whole the proportion was lower in the acute microsystems. In three acute microsystems it ranged from 63% to 71% and from 75% to 90% in three of the community microsystems. This aspect of teamwork was least likely to happen in the emergency admissions unit (33%) and in the first adult community nursing service (59%).

Table 53. How many core members are there in your team?

How many core team members		Micro-system								Total
		EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT	
2-5	No.	9	10	12	0	12	0	2	4	49
	%	20.0%	12.7%	18.2%	.0%	41.4%	.0%	7.4%	12.9%	16.3%
6-9	No.	7	23	18	3	12	4	15	1	83
	%	15.6%	29.1%	27.3%	18.8%	41.4%	50.0%	55.6%	3.2%	27.6%
10-15	No.	1	14	6	5	1	3	10	2	42
	%	2.2%	17.7%	9.1%	31.3%	3.4%	37.5%	37.0%	6.5%	14.0%
More than 15	No.	26	26	27	8	4	1	0	21	113
	%	57.8%	32.9%	40.9%	50.0%	13.8%	12.5%	.0%	67.7%	37.5%
No answer	No.	2	6	3	0	0	0	0	3	14
	%	4.4%	7.6%	4.5%	.0%	.0%	.0%	.0%	9.7%	4.7%
Total	No.	45	79	66	16	29	8	27	31	301
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Staff working in the acute microsystems reported working with a higher number of core team members than community microsystems except for the rapid response team (Table 53). This is a much a reflection of the size of the service than anything else.

Table 54. Occupational group

Occupational Group	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
Allied Health professional	No. 0	0	0	0	0	0	0	0	11	11
	% .0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	35.5%	3.7%
Medical and Dental	No. 2	0	11	3	0	0	0	0	0	16
	% 4.4%	.0%	16.7%	18.8%	.0%	.0%	.0%	.0%	.0%	5.3%
Registered Nursing and Midwives	No. 27	65	25	9	19	8	23	3	179	179
	% 60.0%	82.3%	37.9%	56.3%	65.5%	100.0%	85.2%	9.7%	59.5%	
Nursing or Healthcare Assistant	No. 16	14	29	4	10	0	4	17	94	94
	% 35.6%	17.7%	43.9%	25.0%	34.5%	.0%	14.8%	54.8%	31.2%	
Social Care	No. 0	0	1	0	0	0	0	0	1	1
	% .0%	.0%	1.5%	.0%	.0%	.0%	.0%	.0%	.3%	
Total	No. 45	79	66	16	29	8	27	31	301	301
	% 100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

The majority of staff who responded to the survey were registered nurses or midwives (59%). The next largest occupational group were nursing and healthcare assistants (31%) (Table 54). The highest proportion of medical staff worked in medicine for the elderly (17%) and haematology (19%). Not surprisingly the rapid response team had a high proportion of allied health professionals (35%) (Paramedics). This microsystem also had the highest proportion of nursing and healthcare assistants (55%), followed by medicine for the elderly (44%).

Table 55. Highest level of educational qualifications

Highest level of qualification	Micro-system									Total
	EAU	Maternity	M for E	Haematology	ACNS1	CMS	ACNS2	RRT		
Postgraduate qualification	No. 0	0	10	5	4	3	3	3	28	28
	% .0%	.0%	15.2%	31.3%	13.8%	37.5%	11.1%	9.7%	9.3%	
University degree	No. 26	46	26	10	14	5	13	11	151	151
	% 57.8%	58.2%	39.4%	62.5%	48.3%	62.5%	48.1%	35.5%	50.2%	
A-levels, Vocational A-Levels or AS levels	No. 2	10	3	0	1	0	4	2	22	22
	% 4.4%	12.7%	4.5%	.0%	3.4%	.0%	14.8%	6.5%	7.3%	
CSEs, CSEs, O-Levels	No. 12	15	6	1	6	0	5	7	52	52
	% 26.7%	19.0%	9.1%	6.3%	20.7%	.0%	18.5%	22.6%	17.3%	
NVQ level 1,2,3	No. 3	7	14	0	1	0	0	5	30	30
	% 6.7%	8.9%	21.2%	.0%	3.4%	.0%	.0%	16.1%	10.0%	
Other	No. 1	0	6	0	0	0	1	0	8	8
	% 2.2%	.0%	9.1%	.0%	.0%	.0%	3.7%	.0%	2.7%	
No academic qualifications	No. 1	0	1	0	2	0	1	2	7	7
	% 2.2%	.0%	1.5%	.0%	6.9%	.0%	3.7%	6.5%	2.3%	
No answer	No. 0	1	0	0	1	0	0	1	3	3
	% .0%	1.3%	.0%	.0%	3.4%	.0%	.0%	3.2%	1.0%	
Total	No. 45	79	66	16	29	8	27	31	301	301
	% 100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

The majority of staff who responded either had a postgraduate qualification or a university degree (59%) (Table 55). Highest levels of qualification (university degree and above) were found in haematology (94%) where there were more medical staff, and in the community matron service (100%) which by its nature would be employing staff with higher levels of qualifications. Staff employed in the rapid response team had comparatively lower levels of qualifications with less than half (45%) qualified to degree level. For a number of staff employed in medicine for the elderly (21%) and the rapid response team (16%) NVQs were their highest qualification.

Appendix 22 Additional analyses for Chapter 7

To check the robustness of the results of the main analysis presented in Chapter 7 four additional sets of analyses were performed designed to test the sensitivity of the results to the use of different model specifications, ways of measuring patient care performance and data samples, and in order to explore key interaction effects in our data. The results of these additional analyses are presented below.

Use of different measures of patient care performance

The first additional set of analyses was designed to check the extent to which our results may be sensitive to the use of different measures of patient care performance. In particular, we wished to check whether the use of self, as opposed to supervisor, ratings of performance might make a difference to the analysis. We could only do this indirectly since we had both self-ratings and supervisor ratings of in-role performance (relational and functional) for only a subset of 62 panel respondents. For this subsample of respondents, however, we were able to compare the correlations between each of the independent variables in the model measured at time 1 and the time 2 self and supervisor ratings of in-role performance respectively. The results of this analysis, available from the authors, show that the vast majority (83%) of the correlations using the self-ratings of performance were essentially the same as those using the supervisor ratings. Although caution is clearly required in drawing conclusions from this analysis, these results increase confidence in the value and validity of the self-ratings of performance employed in the study, suggesting that their use is unlikely to have unduly affected or distorted the results of the main analysis.

Effect of positive bias in the panel sample

The second set of additional analyses was designed to check whether the positive bias in the panel sample may have influenced the results of the main analysis. Again, we could only check for the possible effects of positive bias in the panel sample indirectly by comparing the cross-sectional correlations between each of the independent variables in the model at time 1 and each of the performance variables also measured at time 1 for the group of panel respondents with the corresponding time 1 correlations for the group of non-panel respondents (i.e. those employees that participated in the survey at time 1 but not at time 2). The results, available from the authors, show that half (50%) of the correlations involved are the same for

the panel and the non-panel respondents (i.e. the corresponding correlations for the two groups are either both not significant or, if significant, they are in the same direction and broadly of the same magnitude). The rest of the time 1 correlations differ between the two groups. However, there does not appear to be any systematic difference or bias in the two set of correlations in that, of the correlations that are different between the two groups, half are stronger for the panel subsample and the other half are stronger for the non-panel subsample. Overall, therefore, to the extent that it is possible to generalise from these time 1 results, it would appear that the positive bias in the panel sample is not necessarily associated with any clear or systematic positive or negative bias in the relationship between the independent and dependent variables in our model. In other words, the results of this additional analysis suggest that the main results may not be systematically influenced or distorted by the positive bias in the panel sample, thereby increasing confidence in the validity and generalisability of the results of the main analysis.

In this context, it is also worth comparing the cross-sectional time 1 correlations for the panel subsample with the corresponding time-lagged (time1-time2) correlations for the panel sample shown in Chapter 7. Half (50%) of the cross-sectional time 1 correlations involved are the same as the time-lagged correlations (i.e. the corresponding cross-sectional and time-lagged correlations are either both not significant or, if significant, they are in the same direction and broadly of the same magnitude). However, nearly twice as many of the remaining cross-sectional correlations are significantly stronger than the corresponding time-lagged correlations. This pattern is not surprising. It is consistent with the operation of stronger common method variance effects that are likely artificially to inflate relationships between variables in cross-sectional than in longitudinal data, thereby reinforcing the value of testing our model of the antecedents of patient care performance with appropriately time-lagged data.

Sensitivity to alternative model specifications

The third set of additional analyses was designed to check the extent to which the results of the main analysis are sensitive to different model specifications. Multicollinearity does not appear to be a problem in the main analysis. However, because of the relatively small size of the panel sample, combined with the moderate to high correlations between some of the antecedents in the model, it is possible that the effects of some of the antecedents on performance may either be masked or suppressed when they are all entered simultaneously in the analysis. In particular, we wished to check whether the unexpected positive effect of emotional exhaustion on patient care performance may be a function of potentially complex suppression effects due to the simultaneous inclusion in the main analysis

of all three measures of wellbeing. To this end, we ran three further separate sets of analyses using, in each case, only one of the three wellbeing variables at the time as a predictor of performance, along with all the other variables in the original model. Specifically, in the first set of analyses we included only job satisfaction as a wellbeing predictor in the regressions, while in the second and third analyses only emotional exhaustion and relative positive affect, respectively, were included in the regressions.

The new results for the three wellbeing variables, available from the authors, do not differ greatly from the corresponding results for these variables from the main analysis reported in Chapter 7. Specifically, when emotional exhaustion and relative positive affect are excluded from the analysis, the pattern of associations between job satisfaction and the different dimensions of job performance, although marginally stronger, remains substantively the same as in the main analysis (see Chapter 7). The same applies in terms of the pattern of effects of positive affect when job satisfaction and emotional exhaustion are excluded from the analysis. Similarly, the removal of job satisfaction and positive affect from the analysis does not materially change the pattern of associations between emotional exhaustion and performance which remains significant and consistently positive across all dimensions of performance (see Chapter 7). Taken as a whole, therefore, these additional sensitivity analyses suggest that the results of the main analysis concerning the effect of wellbeing on patient care performance are quite robust in that they remain substantially the same irrespective of whether the impact of the three wellbeing variables is examined separately or simultaneously.

Key interaction effects

The last set of additional analyses is explicitly designed to extend the main analysis by exploring key moderator effects in the panel data by examining a number of possible interactions between some of the core variables in our model. Clearly, there are a large number of interactions between the different antecedents that may be theoretically justifiable and, therefore, worth exploring in more detail. However, as noted, our primary interest in the present study is to gain a better understanding of the link between wellbeing and patient care performance. Hence, in order to make the additional interaction analysis manageable we were selective in our approach and focused only on the interaction between the three wellbeing variables with each other and with each of the other situational and individual difference variables in the model.

Specifically, we conducted three separate sets of interaction analyses. In the first set we examined the interaction between the three wellbeing variables themselves. The aim of this analysis is to examine the extent to

which the impact of each of the wellbeing variables on performance varies or is affected (i.e. moderated) by each of the other two wellbeing variables in the model (e.g. the extent to which the impact of job satisfaction on performance is moderated by respondents' level of emotional exhaustion or by their level of relative positive affect). This analysis helps to extend understanding of the effect of wellbeing on job performance by exploring the extent to which different dimensions of wellbeing interact with each other either to magnify or dampen possible performance effects. That is to say, this analysis can help to shed light on the extent to which different dimensions of wellbeing may combine with each other to produce performance effects that are above and beyond the effect that may be produced by each dimension separately.

In the second set of interaction analyses we focused on the interaction between the three wellbeing variables and the two situational climate variables. The aim of this analysis is to contribute to a better understanding of the effect of wellbeing on performance by examining whether the wellbeing-performance relationship is moderated in any way by the climate for patient care at organisational or local level. In particular, the aim is to examine whether organisational or local climate help either to enhance or dampen the effect of each of the wellbeing variables on performance. Finally, the last set of interactions is designed to examine the interaction between the wellbeing variables and the individual difference factors. The aim is to determine whether the wellbeing-performance relationship is affected in any way by individuals' affective patient orientation, their sense of dedication to work, or by their level of job skills and competence. This, in turn, can help to provide a better understanding of the individual level conditions under which wellbeing is likely to have the greatest impact on performance. Note that because of the exploratory nature of the interaction analyses outlined above, we do not specify any formal hypotheses linked to these additional analyses.

The results of the interaction analyses are summarised in Table 56. In all analyses we used the interaction between antecedent variables at time 1 to predict job performance at time 2. To simplify the presentation of the results, only the coefficients of the relevant interaction terms are shown in the table. The full results of the interaction regressions are available from the authors. Panel (a) of the table shows the results of the interactions between the various wellbeing variables, while panels (b) and (c) show the results of the wellbeing x climate interactions and of the wellbeing x individual difference variable interactions respectively. To reduce multicollinearity in these analyses, we first mean-centred all the time 1 variables used to construct the interaction terms shown in the table prior to multiplication (364).

Table 56. Summary of interaction analyses

Antecedent Interactions at Time 1	Relational Performance Time 2	Functional Performance Time 2	Helping Behaviour Time 2	Continuous Improvement Behaviour Time 2	Overall In-role Performance Time 2	Overall Discretionary Performance Time 2	Overall Performance Time 2
Panel (a): Wellbeing Interactions							
Job satisfaction x exhaustion	-.150*	-.218*	-.127	-.097	-.207**	-.133*	-.136***
Job satisfaction x positive affect	-.102	.174**	.115	.042	.157**	.089*	.118***
Exhaustion x positive affect	-.102	-.196**	-.245**	-.127*	-.171*	-.213***	-.170***
Panel (b): Wellbeing x Climate for Patient Care Interactions							
Job satisfaction x organisational climate	.042	.043	.075	.104*	.046	.113**	.011
Exhaustion x organisational climate	-.024	-.125	-.103	-.089	-.091	-.118**	-.034
Positive affect x organisational climate	.037	.068	.074	.058	.060	.082	.018
Job satisfaction x local climate	.038	.083	-.027	.024	.071	.003	.054
Exhaustion x local climate	-.003	-.090	.067	.019	-.059	.044	.004
Positive affect x local climate	.001	.084**	-.137*	-.125*	.055***	-.151**	-.037
Panel (c): Wellbeing x Individual Difference Variable Interactions							
Job satisfaction x affective orientation	.150*	.196**	.133*	.012	.192***	.075	.204***
Exhaustion x affective orientation	-.042	-.092	-.172*	-.164*	-.077	-.191***	-.085

Positive affect x affective orientation	.125*	.228**	.069	.023	.201***	.049	.165***
Job satisfaction x work engagement	.200**	.234***	.089	.054	.238***	.081	.226***
Exhaustion x work engagement	-.131***	-.158***	-.144	-.097	-.158***	-.139	-.077
Positive affect x work engagement	.077	.126***	.073	.017	.114**	.049	.084*
Job satisfaction x job skills	.192***	.190***	.100	.029	.206***	.071	.174***
Exhaustion x job skills	-.159**	-.119*	-.134**	-.051	-.144**	-.103*	-.117***
Positive affect x job skills	.120	.149*	.082	-.071**	.147*	-.006	.105*

Standardised estimates: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Wellbeing interactions

As can be seen from panel (a) of Table 56, 15 of the 21 interaction effects (71%) involving the wellbeing variables are significant. The strongest and most consistent interactions are those between relative positive affect and emotional exhaustion which are significant and negative across six out of the seven measures of performance. Five of the seven job satisfaction x exhaustion interaction effects are also significant and negative, while only four of the job satisfaction x positive affect interactions are significant, and these are all positive. The significant interactions add between 1 and 4 percent of the explained variance in various aspects of performance across the different analyses, indicating that the effects involved are not only statistically significant but also substantively important, i.e. non-trivial.

To aid interpretation of the results, and by way of illustration, the precise form of selected significant interactions is plotted and shown in Figure 36-41. The first indicative example involves the negative interaction between job satisfaction and emotional exhaustion at time 1 on in-role performance at time 2. The negative interaction term ($\beta = -0.207$, $p < 0.01$) indicates that the effect of job satisfaction on performance is stronger at lower than at higher levels of emotional exhaustion. The precise form of this interaction, which is representative of all other significant job satisfaction x emotional exhaustion interactions shown in panel (a) of Table 56, is plotted in Figure 36. As can be seen, the results suggest that exhaustion dampens the impact of job satisfaction on performance. Specifically, in line with theoretical expectations, job satisfaction has a positive effect on performance (see hypothesis 1), but only when emotional exhaustion is low. High levels of exhaustion tend to nullify the positive effect of satisfaction on performance so that when exhaustion is high, satisfaction no longer has a significant positive effect on performance. Exactly the same pattern applies with respect to the significant negative interactions between relative positive affect and emotional exhaustion (Table 56, panel (a)).

Figure 36. Job satisfaction x Emotional exhaustion → In-role performance

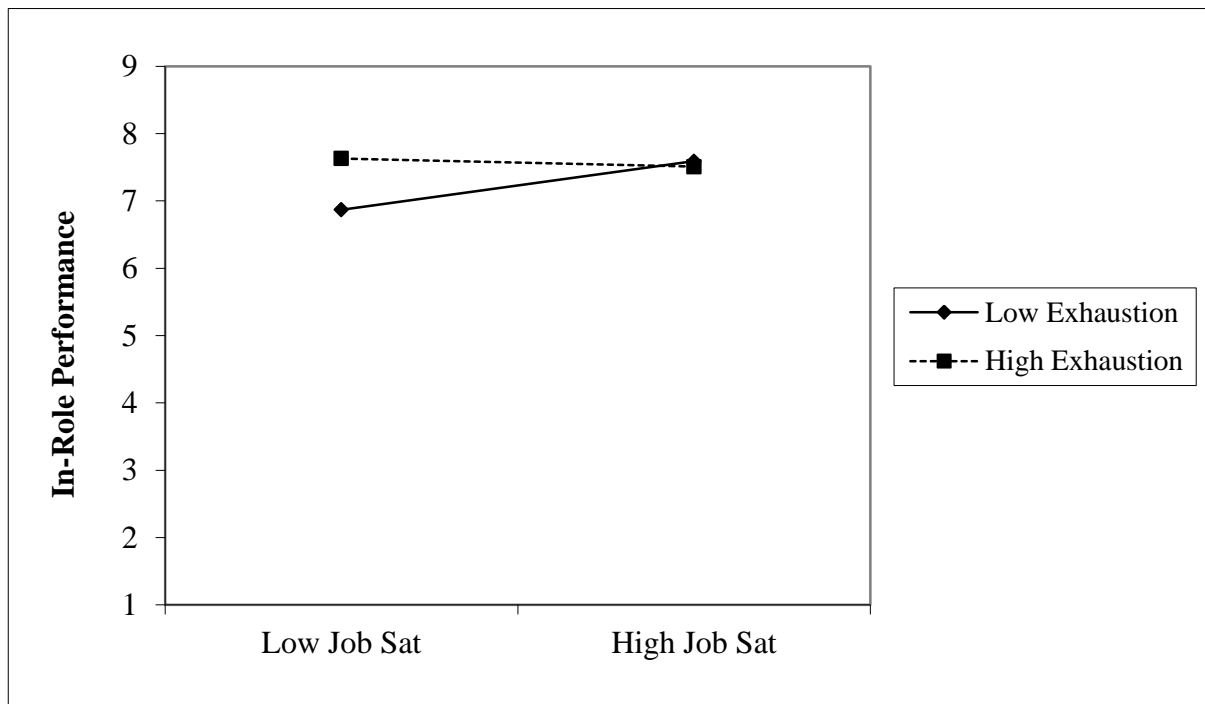


Figure 37. Job satisfaction x Relative positive affect (Pos Aff) → In-role performance

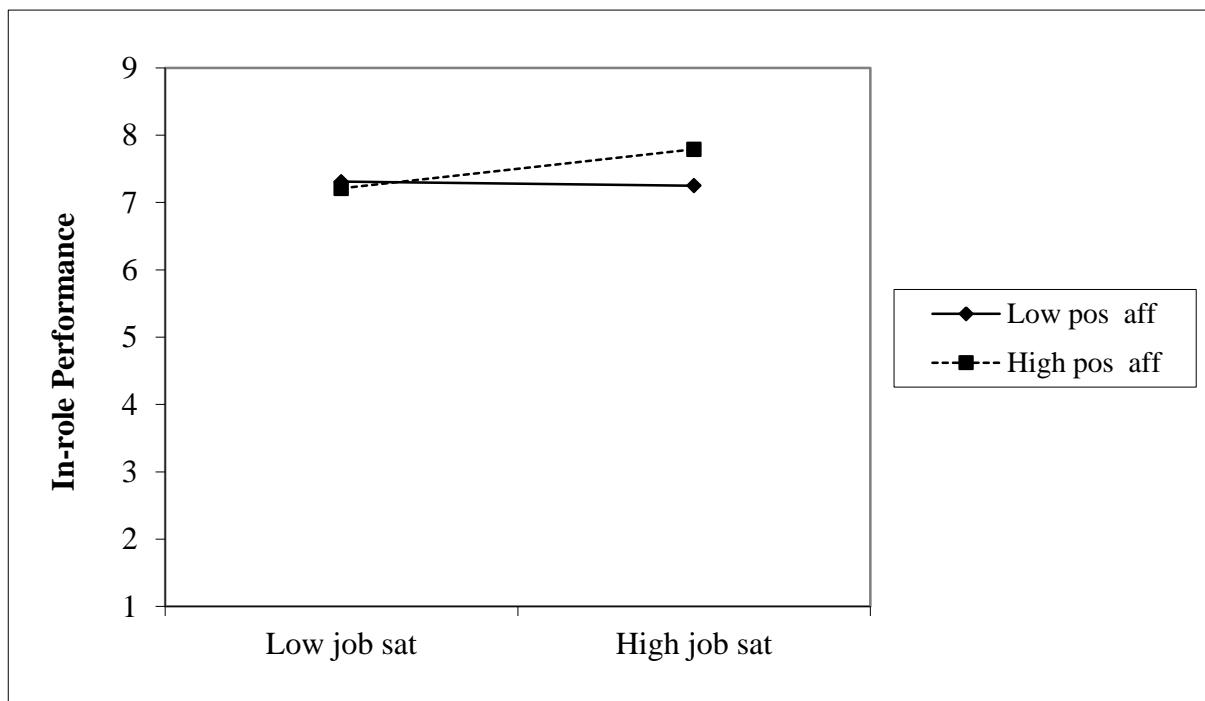


Figure 38. Relative positive affect (Pos Aff) x Local patient care climate → In-role performance

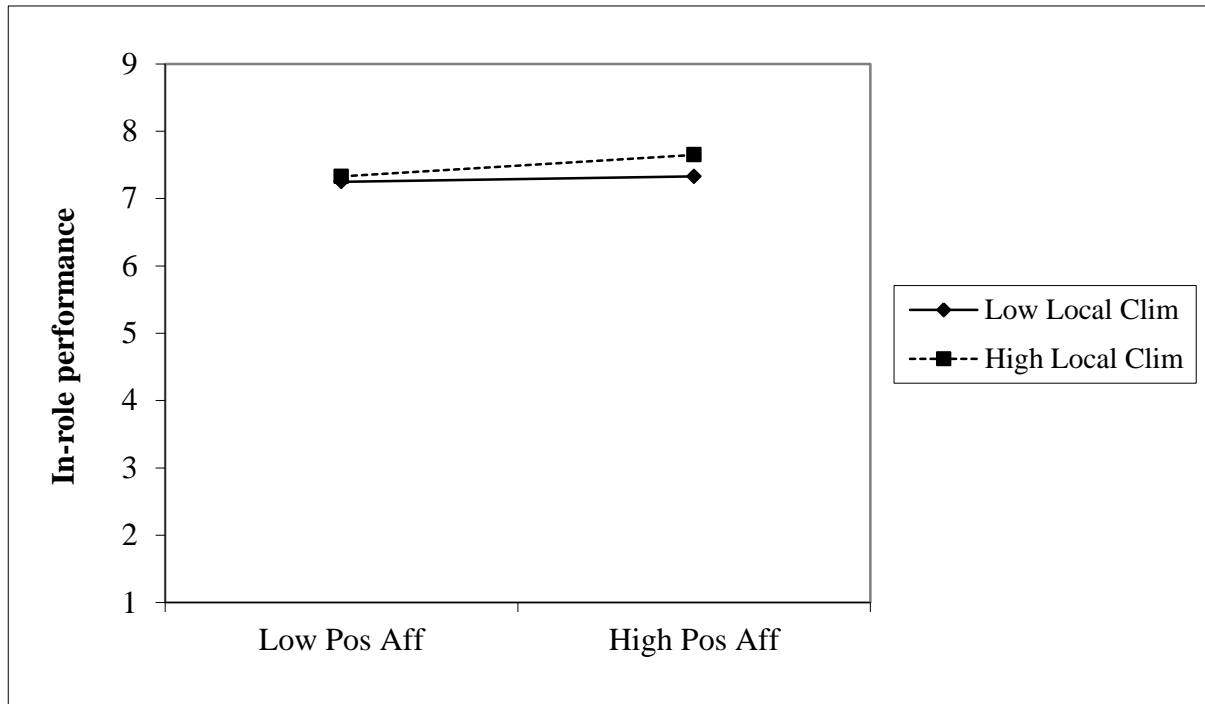


Figure 39. Relative positive affect (Pos Aff) x Local patient care climate → Discretionary performance

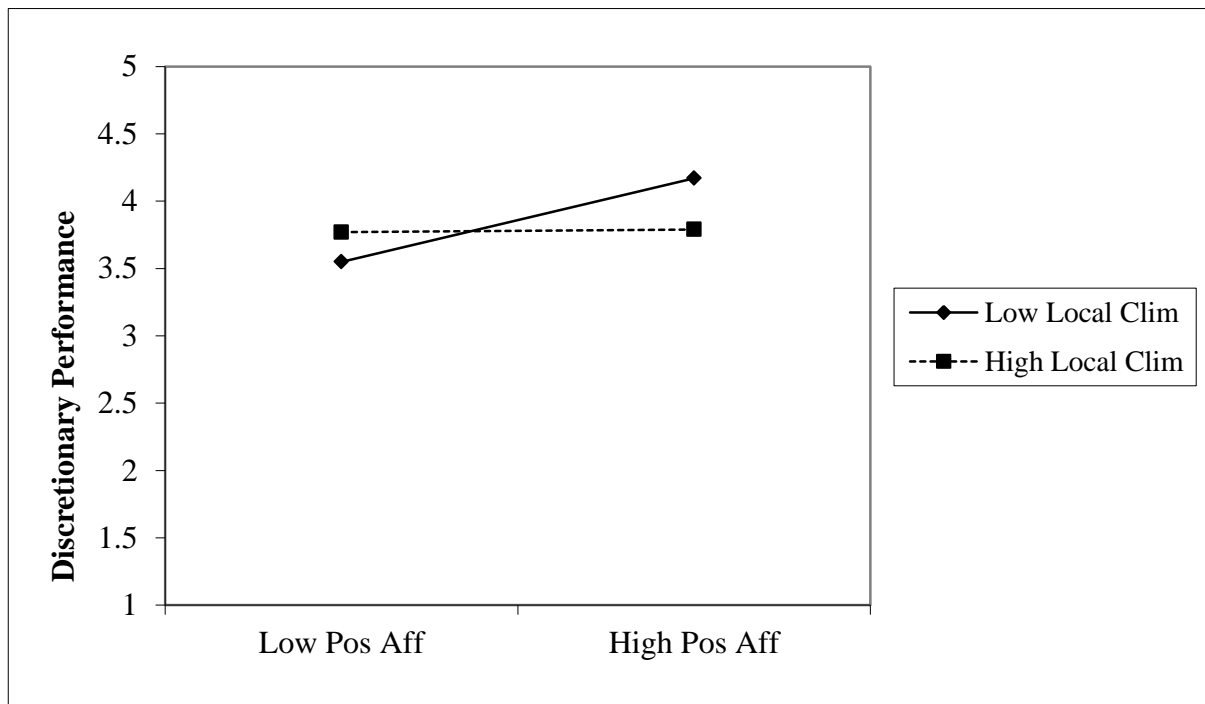


Figure 40. Job satisfaction x Affective patient orientation (Aff Orient) → In-role performance

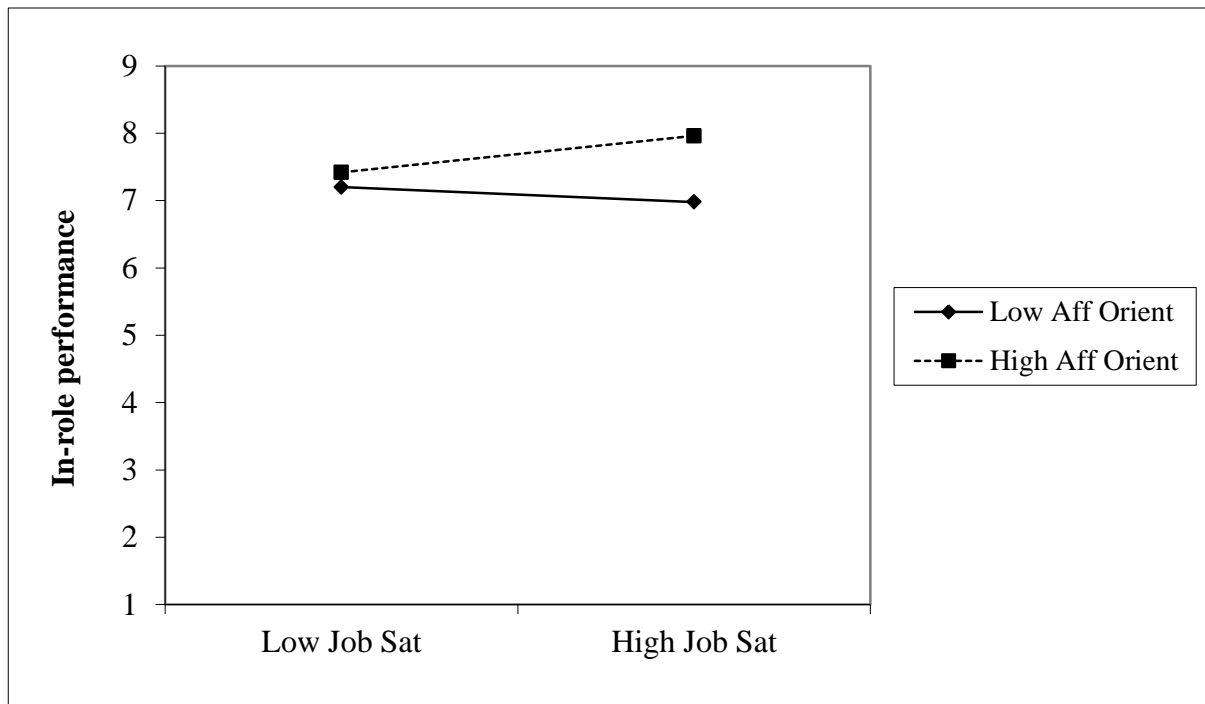
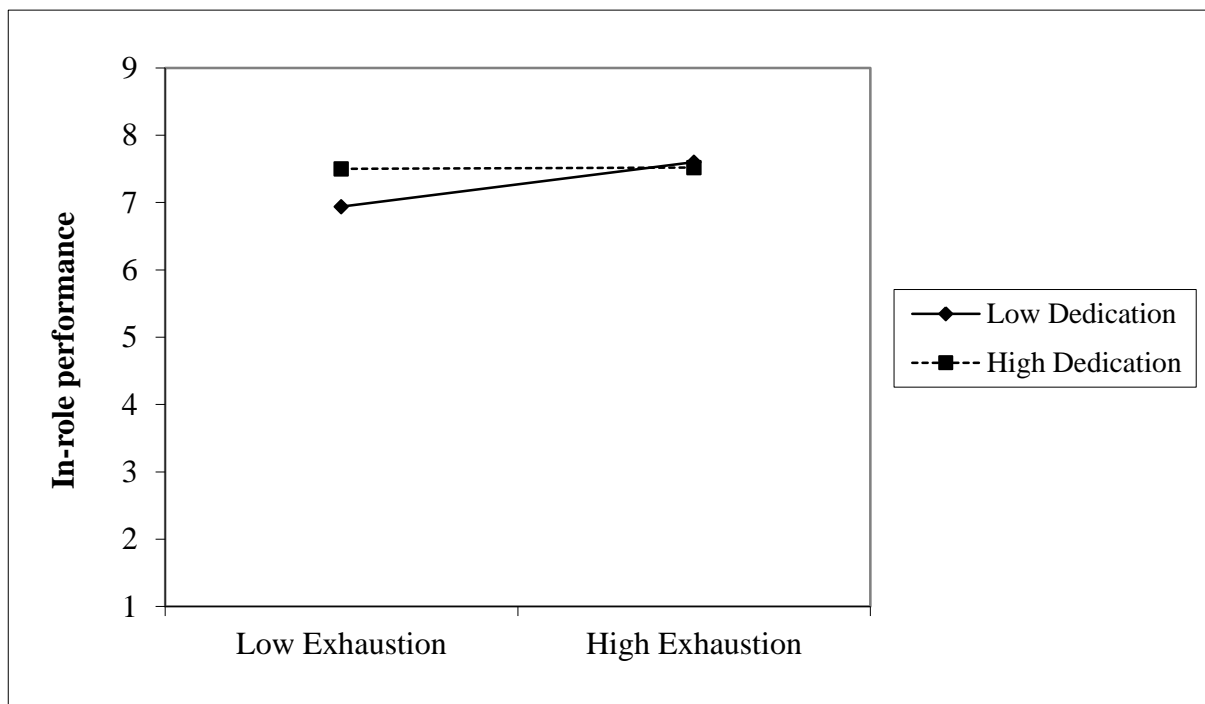


Figure 41. Emotional exhaustion x Work dedication → In-role performance



In contrast, the significant positive interactions between job satisfaction and relative positive affect in panel (a) of Table 56 suggest that the effect of these two aspects of wellbeing on various aspects of performance is mutually reinforcing or complementary, with positive affect enhancing the positive effect of job satisfaction on performance and vice-versa. The specific form of these interactions is illustrated in the example in Figure 37 showing that the relationship between job satisfaction and in-role performance is stronger at higher than at lower levels of positive affect.

Wellbeing x climate for patient care iInteractions

Panel (b) of Table 56 shows that only eight of the 42 wellbeing x climate interactions (19%) are significant, suggesting that climate-related moderation effects are not, on the whole, all that pronounced in our data. For example, none of the interactions between local climate for patient care and either job satisfaction or emotional exhaustion achieve significance. Although not particularly strong, the significant interactions are, nevertheless, non-trivial in that they add between 1 and 2 percent of the explained variance in various aspects of performance across the different analyses.

Generally speaking, two main types of interaction effects can be distinguished here. The first is essentially a complementarity effect whereby a strong local or organisational climate for patient care helps to reinforce the positive impact of wellbeing on performance. The specific form of this complementarity pattern, reflected in the significant positive interactions in panel (b) of Table 56 (e.g. between job satisfaction and organisational climate), is illustrated in the example in Figure 38. This shows that the impact of relative positive affect on in-role performance is reinforced by the local climate for patient care so that positive affect only has a significant positive impact on in-role performance when there is a stronger supportive climate for patient care at local level.

The second type of interaction effect is essentially a substitution one whereby a strong local or organisational climate for patient care can be said to act as a substitute for wellbeing in helping to generate high job performance. In line with (271) arguments about 'strong' situations, strong local or organisational climates for patient care can be expected to help to structure employee behaviour towards patients, generally pushing individuals to higher levels of both in-role and discretionary performance. Strong climates, therefore, can act as a substitute for wellbeing in that they can help to generate high levels of patient care performance even in the absence of wellbeing. Specifically, in strong situations individual behaviour can be expected to be driven more directly by external pressures than by internal feeling states (e.g. wellbeing). As a result, wellbeing can be expected to have a stronger effect on performance when there is a weaker, rather than when there is a stronger, climate for patient care at local or organisational level. This type of substitution effect is reflected in the significant negative interactions in panel (b) of Table 56 (e.g. between

emotional exhaustion and organisational climate), and is illustrated in the example in Figure 39. This shows that the effect of relative positive affect on discretionary performance is more pronounced when there is a weaker local climate for patient care. Where there is a stronger local climate, in fact, positive affect has no significant additional effect of its own on patient care performance.

Wellbeing x individual difference interactions

The last set of interactions between the wellbeing and the individual difference variables are summarised in panel (c) of Table 56. As can be seen, 36 of the 63 interactions involved (57%) are significant. Moreover, the significant interactions are quite evenly spread across the different dimensions of wellbeing and are reasonably strong, adding between 1 and 4 percent of the explained variance in various aspects of performance across the different analysis. Overall, therefore, these interaction results suggest that individual difference-related moderator effects are important for gaining a fuller understanding of the impact of wellbeing on patient care performance.

Once again, two main type of interaction effects can be distinguished, namely, complementarity and substitution effects respectively. Complementarity effects are reflected in the significant positive interactions between the wellbeing variables and the three individual difference variables shown in panel (c) of Table 56. These positive interactions indicate that high levels of affective patient orientation, work dedication and job skills and competence help to reinforce the positive impact of wellbeing on patient care performance. The specific form of these complementarity effects is illustrated in the example in Figure 40. This shows that the impact of job satisfaction on in-role performance is reinforced by an affective orientation towards patients so that job satisfaction only has a significant positive impact on in-role performance when it is combined with a strong affective patient orientation.

In contrast, substitution effects are reflected in the significant negative interactions shown in panel (c) of Table 56 between emotional exhaustion and the three individual difference variables. These negative interactions indicate that emotional exhaustion has a stronger effect on patient care performance at low than at high values of affective patient orientation, work dedication and job skills and competence. The specific form of these substitution effects is illustrated in the example in Figure 41. This shows that the positive impact of emotional exhaustion on in-role performance that was noted in the main analysis is more pronounced when individuals have a weaker sense of dedication to their work. For individuals who report a stronger sense of dedication no significant link is apparent between emotional exhaustion and performance. The same pattern of effects applies in relation also to affective patient orientation and to job skills and competence as moderators of the exhaustion –performance relationship.

In summary, the results of the additional interaction analyses suggest that the relationship between wellbeing and various aspects of both in-role and discretionary patient care performance is quite complex in that it is affected by a range of both contextual and individual factors linked to the climate for patient care at different levels of the organisation and to employee skills and orientations at work.

Appendix 23 Additional analyses for Chapter 8

As in the previous chapter, we conducted a series of additional analyses to check the robustness of the results of the main analysis. Specifically, we performed two additional analyses, the first to check the effects of positive bias in the panel sample, and the second to explore key interactions in the data.

Effect of positive bias in the panel sample

As in the previous chapter, we checked for the possible effect of positive bias in the panel sample indirectly. We did so by comparing the cross-sectional correlations between each of the independent variables in the model at time 1 and each of the dependent wellbeing variables also measured at time 1 for the group of panel respondents with the corresponding time 1 correlations for the group of non-panel respondents. The results, available from the authors, show that nearly all (96%) of the correlations involved are the same for the two groups (i.e. the corresponding correlations are either both not significant or, if significant, they are in the same direction and broadly of the same magnitude). Overall, therefore, the results of this additional analysis suggest that the main results are unlikely to be systematically influenced or distorted by the positive bias in the panel sample, thereby, once again, increasing confidence in the validity and generalisability of the results from the main analysis.

Key interaction effects

An important argument in the job design and JD-R literature is that job control and support, and the availability of job and personal resources more generally, can help to buffer or cushion the negative effect of high job demands on employee wellbeing. In particular, employees who have high levels of job discretion and support, or who enjoy more extensive resources, can be expected to be able to cope more effectively with high job demands and with the strains that such demands are likely to impose. In other words, an important stream of theorising in this area suggests that wellbeing is likely to be lowest in job situations characterised by a combination of high job demands and low levels of resources of various kinds. Overall, evidence in support of this buffering hypothesis is mixed and uneven. Nevertheless, because of the potential importance of these arguments, we decided to test the buffering hypothesis by examining the interaction between job demands and each of the job and personal resource variables in our model.

The procedures used in the present interaction analysis are the same as those we used in the previous chapter. The results of the job demands x resources interactions are summarised in Table 57 below, showing the coefficients of the relevant interactions for each of the three wellbeing variables. The full results of the interaction regressions are available from the authors.

Table 57. Summary of interaction analyses

Antecedent Interactions At Time 1	Job Satisfaction Time 2	Emotional Exhaustion Time 2	Relative Positive Affect Time 2
Job demands x job control	.031	-.165*	.035
Job demands x POS	-.009	-.082	.063
Job demands x supervisor support	-.106*	-.030	-.064
Job demands x co-worker support	-.073	-.054	-.080*
Job demands x job clarity	-.034	-.069	-.053
Job demands x affective patient orientation	-.078*	-.084	-.074
Job demands x work dedication	-.119***	-.022	- .183***
Job demands x job skills and competence	-.098**	-.071*	-.025

Standardised estimates: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

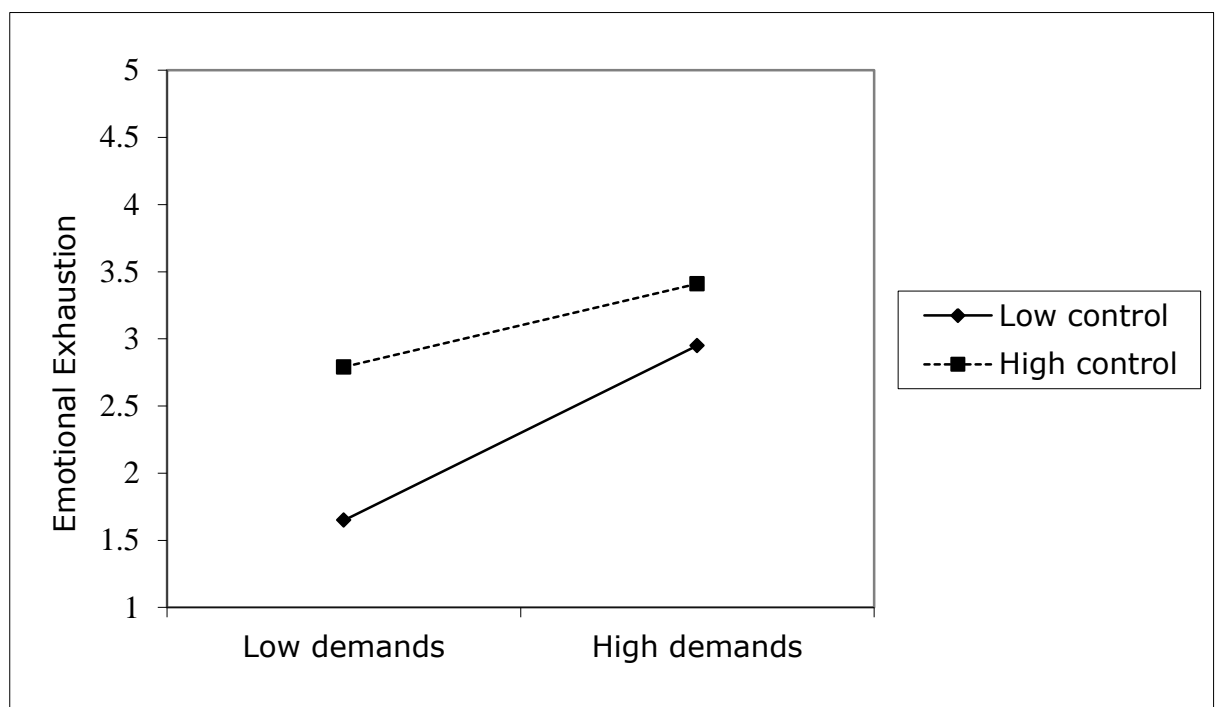
As can be seen, only eight of the 24 (33%) interaction coefficients attained significance. Moreover, although the significant interactions are of substantive importance, they are not particularly strong, adding only between 0.4 and 3 percent (mean = 1.15%) of the explained variance in various aspects of wellbeing across the different analyses. Overall, therefore, the job demands x resources interaction effects involved in our data tend to be uneven and generally rather limited. Nevertheless, the significant interactions are still of interest and add to our understanding of the effect of job demands and resources on employee wellbeing.

Two main patterns of interactions can be identified. The first pattern is in relation to emotional exhaustion. Here, in line with the buffering hypothesis,

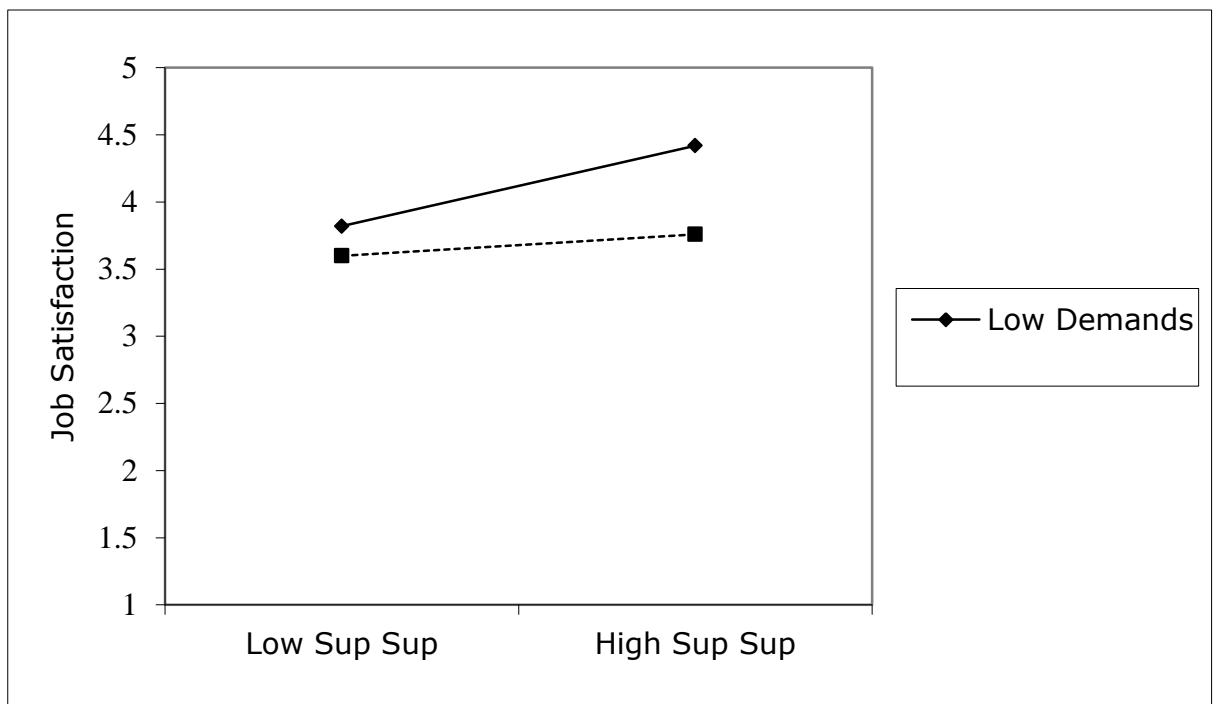
we find that more extensive resources in the form, for example, of high job control and high job skills and competence, help to minimise or reduce the deleterious (positive) impact of high job demands on emotional exhaustion. This buffering effect, which is reflected in the significant negative job demands x job control ($\beta = -.165, p < 0.5$) and job demands x job skills ($\beta = -.071, p < 0.5$) interactions for emotional exhaustion in Table 1, is captured in the illustrative example in Figure 42 (a) showing that job demands have a stronger positive (adverse) effect on exhaustion at higher than at lower levels of job control.

Figure 42. Selected examples of interaction effects

1 (a): Job demands x Job control \rightarrow Emotional exhaustion



1 (b): Job demands x Supervisor support (Sup Sup) → Job satisfaction



The second pattern is in relation to job satisfaction and relative positive affect and can best be understood by looking at the way job demands moderate the effect of job and individual resources on these two aspects of wellbeing at work. As we have seen, in line with JD-R arguments, resources such as supervisor support tend, on the whole, to have a positive effect on job satisfaction and relative positive affect. However, the significant job demands x resources interactions for job satisfaction and positive affect shown in Table 57, suggest that for these two aspects of wellbeing this positive effect is, at least in part, moderated by the level of job demands. Specifically, as shown in the example in Figure 42 (b), the positive effect of resources (i.e. supervisor support) on wellbeing (i.e. job satisfaction) is more pronounced at lower than at higher levels of job demands. More generally, therefore, the interaction results suggest that high job demands can significantly dampen, if not completely nullify, the positive effect of job and individual resources on wellbeing, so that resources are more likely to have a beneficial effect on job satisfaction and positive affect in situations where job demands are less intense.

In summary, the results of the additional interaction analyses suggest that in order to gain a fuller understanding of employee wellbeing, job demands and resources need to be examined simultaneously and conjointly since, to an extent, wellbeing is affected by the combination of these two sets of antecedents.

Appendix 24 Phase II: Summaries of four case studies

The following sections provide summaries of four of our microsystems, those not presented in the main report are presented below. These include two acute services; Maternity and Care of the Elderly and two community; Community Matron Service and Rapid Response Team. Full details are to be found in an Annexe document available as a separate appendix alongside this report.

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 related to the physical environment (cleanliness, heating and the general condition of the ward environments - '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

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 front-line staff felt there was a disconnect between the Trust's senior managers and those at the patient bedside; front-line staff felt senior managers - whilst appearing supportive - did not really want to listen to the detail 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.

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.

1. 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 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 staffshe 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).

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.

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