Lived Experiences of Stress among NHS Mental Health Support Workers: A Qualitative Study

Rita Ojeme

A thesis submitted for the degree of Doctor of Philosophy in Management Studies

Newcastle University Business School

Newcastle University, UK

8 August 2022

Declaration

This is to certify that

(i) The author of this thesis declares that it does not include work forming part of a thesis presented successfully for another degree.

(ii) All work presented represents the author’s own original work except for when referenced to others.

Acknowledgements

This PhD has formed part of my work as a mental health support worker for over four years and would not have happened without the help of several people that I would like to thank.

Thanks to Dr Stefanie Reissner, my first supervisor, who, from the moment we first met, demonstrated the pragmatic, professional and practical approach I needed. She has always been prepared to work around my busy schedules, complying with my timetable, and being flexible enough to meet in a variety of venues.

My thanks also go to Professor Tom McGovern my second supervisor, for continually challenging my somewhat entrenched thinking and highlighting the numerous gaps in my knowledge. I am fully aware how fortunate I am to have had such an expert, knowledgeable, flexible and encouraging supervision team for the full four years. Thanks to my research participants with very limited time available, for agreeing to take part in my study. Thank you for giving your time freely and enthusiastically, and generously sharing experiences that have informed the way I now work. I hope I have done your voices justice.

Thanks to my dear husband, Dr.Emmanuel Ojeme, and my uncle Dr. Akhere Asogun for inspiring me to finally start my PhD studies. Your generous support and sharing of experiences, in respect of both PhD and life in general, have been an essential, and very enjoyable, part of the process for me.

Thanks to my examiners Professor Graeme Martin and Dr Angela Mazzetti for their encouraging, yet challenging, approach to my viva and for the interest shown in, and for the insightful feedback provided on my work.

Finally, thanks to my family: To my dad and mum who, for continually encouraging me to get more and more qualifications; I have finished now. To my sisters, Blessing and Ehiaghe, for the regular encouraging phone calls until this was all over. Thanks to our counsellor Mummy Rhema, for encouraging me to continue to push on with the write up when I gave up several times.

To my children Eleanor, Emmanuel and Elijah, I hope you will forgive me for all the time I spent in the study, rather than with you, it’s all done now.

Table of Contents

List of Tables

Abstract 10

Chapter 1. Introduction 11

1.1.Setting the scene..........11

1.2.The concept of work-related stress..........12

1.3.Stress in the NHS 13

1.4. Methodological approach 17

1.5. Findings and contributions..........18

1.5.1.Theoretical contribution..........*19*

1.5.2. Empirical contribution..........*19*

1.5.3. Methodological contribution..........*20*

1.5.4. Practical contribution..........*21*

1.6.Structure of the thesis..........21

Concluding Remarks..........25

Chapter 2. Literature Review 26

2.1. Introduction 26

2.2. Defining stress 27

2.3. Key theories of stress *29*

2.4. Stress as a multifaceted phenomenon 38

2.4.1. Stress in the life domain *39*

2.4.2. Stress in the work domain *41*

2.4.3. Stress in the organisational domain *42*

2.7 Rationale for the study..........52

2.8. Concluding Remarks..........53

Chapter 3. Methodology..........54

3.1. Introduction 54

3.2. Research philosophy 54

3.3.* Research approach *56

3.4. Methodology..........57

3.5. Data collection..........59

3.5.1.* Qualitative interviews..........*62

3.5.2. Field notes (diary entries) *69*

3.5.3. Documents..70
3.6. Data analysis 71
3.7. Research quality and the role of the researcher (reflexivity) 75
3.8. Research Ethics 77
3.9. Limitations 81
3.10. Concluding Remark..81

Chapter 4. Research context: the organisation of mental healthcare in England 82
4.1. Introduction 82
4.2. The NHS as the UK's main public healthcare provider..83
4.3. Mental healthcare in the UK..86
4.3.1. Mental health awareness 86
4.3.2. Provision of mental healthcare in the UK 87
4.3.3. Funding for Mental Healthcare 90
4.3.4. The workforce in mental healthcare..92
4.3.4. The role and duties of mental health support workers within the NHS 94
4.4. The Trust (research setting) 97
4.4.1 Place of the Trust in the NHS structure 97
4.4.2 Provision of mental healthcare in the Trust 99
4.4.3. Care for the workforce 100
4.5. Concluding Remarks..103

Chapter 5. Organisational domain 105
5.1. Introduction 105
5.2. Change, innovation and efficiency..106
5.3. Resource constraints..112
5.3.2. Understaffing 116
5.3.3. Development opportunities 121
5.4. Organisational culture 125
5.4.1. Lack of involvement in decision making 126
5.4.2. Employee voice and recognition..127
5.4.4. Allocation of work 133
5.5. Organisational Policies and Guidance..136
5.5.1. Sickness policy and implementation 136
5.5.3. Disciplinary issues 142
5.5.4. Lack of flexible working 143

5.6. Concluding Remarks 145

Chapter 6. Workplace domain 147
6.1 Introduction 147
6.2. Workplace environment 147
6.2.1. Challenging patient behaviour 151
6.3. Workplace misbehaviour 156
6.3.1. Staff-to-staff conflict 156
6.3.2. Manager-staff relationships 159
6.3.3. Discrimination 165
6.3.4. Ethos of care/lack of support 171
6.4. Concluding Remarks 179

Chapter 7 – Home domain 182
7.1. Introduction 182
7.2. Nature of work 182
7.2. Personal factors 188
7.2.1. Poor pay 188
7.2.2. Relationships and caring 190
7.3. Mental health challenges 197
7.4. Concluding Remarks 203

Chapter 8. Discussion 204
8.1. Introduction 204
8.2. Key aspects of mental health support workers' lived experience 204
8.2.1. Lack of professional recognition 204
8.2.2. Replaceability 207
8.2.3. Involvement in decision making 208
8.2.4. Lack of care 209
8.3. Concluding Remarks 211

9.0. Conclusion 213
9.1. Introduction 213
9.2. Key Findings 213
Addition to knowledge 214

9.3. Contributions....214
9.3.1. Theoretical contribution....214
9.3.2. Empirical contribution....216
9.3.3. Practical contributions....217
9.3.4. Methodological contribution....219
9.4. Reflections on the lived experiences of mental health support workers 220
9.5. Limitations 222
9.6. Further research....222
9.7. Concluding Remarks....223

References....225

Appendix....
Appendx 1- Debriefing sheet/email template....257
Appendix ii - Debriefing sheet 2 258
Appendix iii - Information sheet 259
Appendix iv- Informed consent 261
Appendix v- Full ethical review form 262
Appendix vi - Clarification about the use of observation and ethnographic - style field notes
Appendix vii- Research protocol 1....274
Appendix viii- Research protocol 2....276
Appendix ix – Extract from the sickness absence policy....279
Appendix x - Guide to flexible working for managers 280
Appendix xi – NHS bereavement policy....288

List of Tables

Table number	Table name	Page number
Table 2.1	Stress Theories	29
Table 3.1	Overview of final study	56
Table 3.2	Study sample	60
Table 4.1	Workforce statistics	89
Table 4.2	Summary of support worker's role	91
Table 4.3	Staff groups/annual pay	92
Table 4.4	Key organisational policies	98

List of Figures

Figure number	Figure name	Page number
Figure 1.1	Final study design	17
Figure 3.1	1st and 2nd order codes	69
Figure 3.2	Theoretical model	70

Abstract

Stress in healthcare has been studied mainly through the eyes of professionally recognised staff such as doctors and nurses. However, little attention has been given to the army of support staff who are providing frontline services. Informed by a qualitative and inductive approach, this study provides pertinent insights into the lived experiences of one such group: mental health support workers, who provide care to mentally ill patients. It contributes to the literature on work-related stress by eliciting a detailed understanding of the personal, interpersonal and organisational factors that cause stress to this understudied group within the UK's National Health Service (NHS).

The empirical material was gathered from 35 semi-structured interviews with mental health support workers, a field diary that captured the researcher's lived experiences as a mental health support worker herself, and internal documents by the Trust in which the study took place. The use of an insider researcher enabled researching **with** rather than researching **on** mental health support workers, enabling an in-depth understanding of participants' interpretations of what causes stress, its manifestations, and the institutional mechanisms aimed to address and reduce stress within the workplace.

The findings demonstrate that mental health support workers face additional stressors that other healthcare professionals such as doctors and nurses are not exposed to. These include lack of professional recognition, replaceability, precarity of pay and working conditions, lack of employee voice and feelings of not being valued. Together, these make mental health support workers more susceptible to stress and less resilient to cope with it. Thus, these findings raise a number of pertinent questions for researchers, managers and policymakers regarding precarity of work, professionalisation and the prevalence of clinicians performing managerial roles.

Chapter 1. Introduction

1.1. Setting the scene

> Almost all the cases of sickness absences I have had in the last three months have been work-related stress, and they have been legitimate work-related stress, and I think it is due to immense pressure for clinical staff – that prolonged concentration and the number of days at work; they have no time and they have to document each activity they have undertaken for the day or weekly basis because of the nature of their job role, and I think that is a pressure. – P16 (Manager)

This thesis examines work-related stress among mental health support workers in one Trust in the UK's National Health Service (NHS) at the organisational, workplace and personal levels. Mental health support workers work with patients living with mental illness, including their families and carers, by providing day-to-day support to help them meet their needs (NHS England 2022). Their work does not involve specific mental health treatment; rather, their primary focus is contributing to the mental health and wellbeing of their patients by providing general support, which is carried out under the guidance of other qualified mental health professionals (NHS England 2022). From my experience as a mental health support worker, these staff provide care for some of the most seriously ill patients and work in environments that are unpredictable and challenging. This area of nursing therefore needs staff who are physically and mentally fit for purpose. Their roles and duties are discussed in Chapter 4 of this thesis.

However, our understanding of who they really are, what they do, their job descriptions and the competencies they possess has been largely neglected (Buchan 2019; Thornley 2000). Mental health support workers can be considered as non-professionally affiliated (NPA): a term used to describe anyone working in a support, assistant or otherwise non-professional qualified role (Harrison 2011). While studies into work stress in mental health nursing are few, studies specifically looking at mental health support staff are even fewer.

To address this imbalance, this study firstly investigates who mental health support workers are, what they do, and the competences they possess. Secondly, it examines the causes of stress amongst mental health support workers and a Trust's response to help this group of workers cope with stress. This research seeks to create

a better understanding of mental health support workers' experiences of stress, and particularly what triggers stress for them, and how experiences of stress can be managed effectively from organisational, management, and personal perspectives. Finally, this study investigates the type of (further) support mental health support workers may need to carry out their demanding work in a sustainable manner.

This introduction chapter identifies the motivation behind the choice of the research topic and provides the context for investigating the factors causing stress and impacting on the working conditions of these staff. It concludes with an outline of the structure of the thesis and its contributions to knowledge.

1.2. The concept of work-related stress

Stress is a reaction to events or experiences in someone's home life, work life or a combination of both (Tocino-Smith 2019). Specifically, work-related stress is experienced at or in relation to work and is defined as a response people may experience due to excessive pressures or from other demands within the context of work (Parkyn and Wall 2020; HSE 2022). This means that it can be best described as the reaction people feel when the demands placed on them exceed their ability to cope (Donaldson-Fielder et al. 2011).

Although stress can be defined, it is experienced by people in different ways. While some people cope well with stress, others become physically ill, suffering from insomnia, altered eating patterns, changes in mood, exhaustion, inability to concentrate, and alcohol and drug abuse (HSE 2020). These symptoms of work-related stress can sometimes present themselves in combination by aggravating any pre-existing mental health disorders such as depression and anxiety (HSE 2020; Li et al. 2016). Such symptoms are often not attributed to stress but to exhaustion (Donaldson-Fielder et al. 2011).

Stress is more prevalent in public sector occupations such as health and social care because such occupations face enormous work pressure and demands, and increased workload amidst staffing shortages due to increasing staff absences (HSE 2022). However, different occupations have their own specific stressors that are

intrinsic to the nature of the job; for example, caring for ill people where there are limited resources in healthcare settings. These stressors may be personal: entrapment in the job, financial burden (Kulkami et al. 2014), limited access to healthcare facilities and shortage of trained healthcare workers (Abbas et al. 2017). There are also correlations between observed stress and certain working characteristics; these include the number of hours worked, lack of support at work from employers, demanding working environments and exposure to certain physical agents. Those reporting to be highly stressed are seen to have health problems and are prone to accidents at work (McKay et al. 2006).

There are scientific studies differentiating between eu-stress, commonly referred to as positive stress, and dis-stress, known as negative stress; these suggest that “A little bit of stress is good for you” (Tocino-Smith 2019; Mills, Reiss and Dombeck 2018; Brule and Morgan 2018; Li et al. 2016). This traditional view of stress implies that if we do not experience stress, we are not striving to become our best selves as humans (Tocino-Smith 2019), although this is controversial (Donaldson-Fielder et al. 2011). According to these debates on stress, a little bit of stress may be good for mental health support workers as human beings because it can make us prepared to face the challenges that come our way. But at the same time, individuals, managers and organisations should try to minimise stress as much as possible because of the potentially detrimental effects.

1.3. Stress in the NHS

Stress is widespread among NHS staff, with 4 in 10 of them having to take sickness absence due to work-related stress (Webber 2021). Research suggests that levels of work-related stress appear to be more prevalent in the NHS than other similar professions (Ravalier et al. 2020). Current research has shown that stressors include changes to workload, organisational change, home-life issues, illnesses and global pandemics (HSE 2022). However, there are reports from extant research which suggest that factors contributing to work-related stress include workload, time constraints to complete tasks, lack of skill sets and role clarity, inability to cope with demands, and resource constraints (HSE 2020). Work-related stress costs the

economy, industries, organisations and most importantly the healthcare system large sums of money yearly, both directly and indirectly (Gaines 2015). Recent studies estimate that stress-related sickness absence costs the NHS up to £400 million per year (Ravalier et al. 2020) which is a higher-than-average level compared to other parts of the public sector and all other professions (HSE 2022).

Inpatient mental health nurses make up a significant proportion of nurses, but their profession is often vaguely articulated, and therefore poorly comprehended outside of the professional inpatient environment (Delaney et al. 2014). Mental health nursing is mainly based around mental illness and dealing with mental health conditions; emphasis is placed on the emotional and mental state of the patients. Staff working in mental health services are at increased risks of harm and violence perpetrated by patients, and it is deemed very demanding work as the prevalence of violence in these settings is very high worldwide (Callaghan et al. 2018). Hence, it is envisaged that staff working in mental health teams may be more vulnerable than those working in the general side of nursing, whose patients present with physical rather than mental illness (O'Connor et al. 2018). These issues are marked differences between the two sides of nursing; therefore, a current lack of understanding is evident in that existing research does not sufficiently explain the life-worlds of these different groups.

According to NHS data in 2017, healthcare assistants and other support staff had the highest sickness absence rate at 5.90%, followed by ambulance staff at 5%. Nurses, health visiting learners and midwifery had the lowest rate of sickness absence at 0.9% (NHS Digital 2017). According to an NHS survey (2020), nearly half the NHS workforce in England (approximately 44%) reported feeling unwell as a result of work-related stress, the highest rate recorded in the last five years (HSE 2022; O'Dowd 2021). According to an NHS staff survey in 2015, 40% of staff reported experiencing stress at work, with one-third of them considering quitting their role and one-fifth considering leaving the NHS entirely (West 2016; Rimmer 2018). This means that it may be difficult for frontline staff such as mental health support workers, and other healthcare workers such as nurses and doctors, to provide the high-quality care expected from them (Ruotsalainen et al. 2015).

For the past eight years, I have been a mental health support worker. From my experience as a mental health support worker, staff shortages due to sickness absence

result in increased workload, poor employee wellbeing and excessive pressures leading to people making mistakes. Previous studies have found that the prevalence of stress in the workplace was highest in nurses, followed by physicians (Chou et al. 2014). This suggests that nurses tend to feel more stressed than physicians, which may imply that people further down the organisational pecking order are more susceptible to stress, with support workers bearing the brunt. The mental health workforce is based on those individuals who provide or support the provision of care through mental health services in secondary care (NHS Digital 2022).

My colleagues and I experience stress originating firstly in the ward, when it gets very busy; for example, if there are new admissions of very challenging patients. Also, due to the nature of the ward and the work environment, colleagues are eager to change wards as they feel some are less stressful to work in than others. Secondly, not only do we experience stress originating in the ward, in working with aggressive and abusive patients; we have also seen stress originating in our relationships with superiors, who often wave aside staff concerns and do not take staff feedback regarding stress seriously. Thirdly, line managers do not always appear to provide adequate support to staff when needed, especially when there is precarious workload in the ward that needs to be dealt with. Fourthly, staff are unhappy about rigid shift patterns and the impact of shift work as this sometimes interferes with their lives outside work. Some people insist on having a more flexible approach to duty rotas and shift patterns in order to balance home-life and work. In addition to the above issues, staff are unhappy about being reshuffled across the wards with little notice based on top-down communication from frontline managers. My research participants reported that these issues impacted people both mentally and psychologically, resulting in them either leaving permanently to other jobs or going on sickness leave for long periods of time. I have also seen how these issues impact my colleagues and how this subsequently leads to an increased level of sickness absences.

As a result of these issues, despite being a mother of four young kids and continuing to work, I decided to embark on a PhD to delve into the working lives of mental health support workers. I hope that through my work, I will be able to contribute to the existing literature on work-related stress by elucidating an understanding of what causes stress for this group of staff and how this can be managed by providing a less

stressful environment, with a concomitant reduction in stress among mental health workers in the NHS. These experiences form my personal motivation for undertaking this doctoral research.

Aims and approach of the study

As outlined above, there have been calls for further research into work-related stress among healthcare staff, particularly in relation to mental health settings. This study involves examining the lived experience of work stress among mental health support workers, to increase understanding of how they manage stress and to give a voice to this statistically hidden group.

The overarching research question in response to this call is:

How do mental health support workers experience and mitigate the impact of stress across interrelated domains: organisational, workplace and home?

There is a "gap" in current research in relation to the experiences and impact of work-related stress across interrelated domains – organisational, workplace and home – among individuals working in mental health support. These three are not standalone domains: they impact on each other, and therefore warrant a more systematic, integrated investigation. To address this gap, the normative aim of this study is to gain an understanding of work-related stress among mental health workers in the NHS, considering its causes, manifestations and associated organisational issues, such as the institutional support mechanisms to address and reduce stress among staff.

To understand the role of the group of workers under study, it is important to understand their theoretical grounding in terms of the sociological literature which is central to this study. In doing this, I am taking a sociological approach to the study of work-related stress. Mental health support workers are non-registered staff situated within the sociology of the professions; that is, the body of literature concerned with the relationship between professional and non-professionally affiliated roles such as assistant and support workers and how certain occupational groups achieve and maintain their privileged positions in society (MacDonald 1995; 2006). As highlighted,

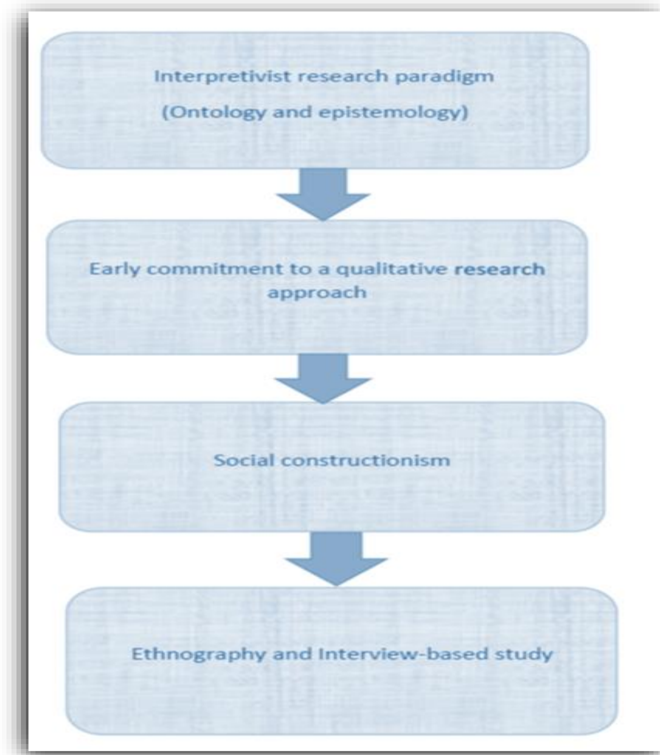
beyond formal recognition, support workers generally differ from nurses in that their job role is different; they lack autonomy and the ability to delegate (see Chapter 4).

1.4. Methodological approach

To achieve its aim and answer the above research question, this study will employ a qualitative methodological approach. Since the phenomenon investigated is a lived experience of my own, adopting this approach has enabled me to attempt to make sense of and interpret the causes of work-related stress among this unique group of healthcare staff by studying the phenomenon in its natural setting (Aspers and Cote 2019). Being an insider researcher is arguably a strength of this study because I already had an understanding of the culture of the Trust, which might take an outsider a longer time to acquire (Smyth and Holian 2008). I also had an established relationship with my research participants, which promotes telling and judging the truth of a particular situation. I was able to explore issues relating to the current study in more depth, which may have a direct impact in theory and practice. However, I was aware of the possible effects of perceived bias in relation to data collection and analysis, and of respecting ethical issues relating to the anonymity of the Trust and my research participants.

Figure 1.1 represents the methodological framework during the research process and summarises the results of my considerations as the study developed, moving from an interpretivist paradigm and qualitative approach to the final choice of an interview-based study with some auto ethnographic element.

Figure 1.1. Methodological Framework



The final choice of an interview-based study was based on the decision to focus on mental health support workers' individual accounts of their experiences. I saw this as the most suitable method of gaining insight into this type of research.

In terms of data analysis, and given the potentially sensitive nature of this study, key ethical issues were raised relating to covert observation and field notes (see Chapter 3). In response to the university ethics committee's concerns, written strategies outlining how I intend to keep a field diary during my shifts were submitted to the ethics committee. This can be found in (Appendix VI).

1.5. Findings and contributions

To contextualise this research, it is necessary to understand the factors leading to work stress among mental health support workers. The first part of this chapter has provided an overview of the concept of work-related stress and stress in the NHS, including the aim, rationale and motivation of this research.

The final part of this chapter outlines the main contributions of this thesis and the structure of the research. A range of insights are provided into the experiences, requirements and expectations of a unique group: mental health support workers. It also discusses the differences between mental healthcare and the general side of nursing. This makes a useful contribution to the understanding of this expanding and increasingly important, yet unrecognised sector of the healthcare workforce (Buchan 2019).

1.5.1. Theoretical contribution

This research contributes to the growing body of research on work-related stress, particularly in the healthcare sector. Prior research has tended to present stress as an isolated phenomenon in a particular domain of people's lives.

However, through early attention to potential overlaps between different domains of a person's life, this research elucidates how factors originating in one life domain may affect other life domains. The analysis identified three interrelated domains that interviewees alluded to: (1) organisational domain, (2), workplace domain, and (3) life domain. Such relationships between domains imply that stress does not exist in an isolated or specific domain of people's lives and people may bring their lives and worries from home into work and vice versa. Put differently, it demonstrates through a detailed qualitative and inductive analysis that the workplace, organisational and life domains are interrelated.

1.5.2. Empirical contribution

The empirical contribution of this study is that it has examined the experiences of stress among an important yet understudied group of healthcare workers in the NHS – mental health support workers. Moreover, while there is a growing body of research on stress in nursing, the primary focus of research on stress in healthcare has been on professionally accredited staff groups, such as doctors and nurses, and also on the general side of nursing rather than mental health nursing (Naylor 2016; Dickens 2019; Cooper and Mitchell 1990). This means that mental healthcare has been studied less rigorously than general healthcare, despite it arguably being more complex and

challenging in nature. This empirical gap forms the contextual backdrop to this PhD study.

1.5.3. Methodological contribution

The relatively small amount of research on stress among healthcare staff tends to be quantitative and experimental, focusing on one or two main occupational groups – nurses or doctors (Al-Ruzzieh and Ayaad 2021; Khamisa et al. 2016). As earlier stated, prior research has focused on one domain of workplace stress, such as the organisational domain (Khamisa et al. 2016; Parkyn and Wall 2020; Di Fabio 2017; Donaldson-Fielder et al. 2011; Havermans et al. 2018) or the personal domain (Freeburn and Sinclair 2009), rather than a more holistic view of stress as taken in this research.

In contrast, as outlined above, this study has employed a qualitative and ethnographic methodological approach using an insider-researcher. By being both a mental health support worker and a doctoral student, I was able to act as a "practitioner-researcher" (Saunders et al. 2009:598) and "insider-outsider" (Humphrey 2007:11). I have thus been able to both "live" and "become" part of my research question, and I have kept a lived experience diary to capture my mental health support worker experiences.

Since stress affects how individuals experience, understand and live out their lives at work, such an approach is an important innovation in stress research. It has allowed me to explore concepts and the experiences of my research participants in more detail. Unlike quantitative or experimental design, I was able to explore participants' attitudes and behaviour in more depth on a personal level, eliciting a better understanding of their views and opinions.

However, a reflexive approach was needed due to the "close relationship between the researcher and researched" (Blaxter et al. 2006:158). This will be detailed in Chapter 3.

1.5.4. Practical contribution

This research examines an issue that is of prime importance to the NHS as an institution in general and to mental health support workers more specifically. Of course, there are my findings, with a new conceptualisation of workplace stress that integrates other levels. Workplace stress is not an isolated phenomenon; whatever is happening in the workplace is situated in a wider organisational context. There is almost a relationship between these dimensions. Therefore, workplace, organisational and life domains are interrelated, and these kinds of interrelationships are derived from the research itself.

It is hoped that these findings will be beneficial and relevant to HR and line managers, and other NHS Trusts and healthcare professions, as they will experience similar issues where there will always be people at the lower end of the hierarchy like my participants. My approach is thus a fundamental way of looking at ways in which stress can be perceived and challenged.

This study also has implications for HR practice, such as challenging the way stress is perceived, creating a fundamental way in which stress is seen, and creating a new conceptualisation of workplace stress that integrates other levels of stress, as discussed in Chapter 9.

1.6. Structure of the thesis

The remainder of this thesis is made up of the following:

Chapter 2: Literature review

This chapter provides an overview of findings from existing literature on stress and discusses its evolving definitions; it is a contested concept. It also reviews the body of literature on work-related stress among healthcare professions in the NHS, on which this study builds and to which it contributes. The chapter identifies a research gap in terms of workplace stress perceived as a single domain; this prevents meaningful understanding of mental health workers' experiences of work-related stress.

Chapter 3: Methodology and study design

Chapter 3 describes the study's theoretical framework and the choice of methodology and methods. The first section describes how the study was located broadly within an interpretivist framework, which was underpinned by a social constructionist approach. It also details the decision-making process behind the choice of a qualitative, ethnographic and interview-based study. I have categorised my data according to three domains: organisational, workplace and life. These form the headings of the three findings chapters.

The second section then explores key issues related to rigour and quality in qualitative research related to the current study and discusses key issues around ethics. Finally, in keeping with a qualitative, social constructionist tradition, this chapter also provides a reflexive account of my own subjective experience and position in the research.

Chapter 4: Research context: the organisation of mental healthcare in England

Chapter 4 outlines the overview of mental health in the UK with reference to the present economic and societal concerns. It introduces the NHS which is the case organisation for this study, as well as the Trust, and discusses how mental healthcare is delivered in the UK through the NHS.

Chapter 5: Organisational domain

The findings of the empirical research are analysed in Chapters 5 to 7. This includes grouping the data into common themes that emerged from interviews and my ethnographic field notes informed by my observations at work during my shifts.

In this chapter, the empirical evidence gathered revealed key stressors from the organisational domain and the reported themes and concepts from the data analysed, including organisational change, uncertainty, resource constraints and fear of losing one's job. The analysis indicates that the myriad of changes to structures, policy guidance and working practices over the last decade appears to have affected

research participants in many ways. This results in people feeling under pressure and becoming stressed.

Chapter 6: Workplace domain

In the second findings chapter, the stressor themes are discriminatory behaviours, unsupportive management, organisational culture such as lack of involvement in decision making, lack of control, perceived support or the lack of it, staff conflict, poor communication, lack of flexible working and policy guidance and implementation. Also, the ward environment was deemed hostile and aggressive due to challenging patient behaviour, and violence and aggression appeared to be an unavoidable and accepted part of the job.

The key findings highlight that although support is provided for both staff and managers, neither group feels sufficiently supported. Therefore, the research participants would like to have more opportunities to discuss things with their line managers as little issues can lead to significant stress for people who feel threatened by direct experiences or indirect reports of being unfairly blamed for mistakes. These lead to feelings of being unsupported and abandoned by their managers, especially in difficult situations.

Chapter 7: Life domain

The last findings chapter presents stressors from the life domain, such as work-life balance, financial challenges, bereavement, relationship breakdown and caring responsibilities. Key findings demonstrate the difficulties in finding optimal balance between work and home. There appeared to be spill-over from work into people's private lives. Experiencing stress in private life may reduce one's ability to cope with stress, and an inability to cope with stress may also affect one's private life.

Research participants found it difficult to switch off from work even after going home. Key findings also suggest that some staff are faced with challenges of poor health and wellbeing and suffer from mental health issues themselves, which sometimes can be due to stress experienced at the workplace.

Chapter 8: Discussion

The discussion chapter of this study provides a summary of all the findings and positions them within the relevant academic literature overviewed in Chapter 2. The main deductions drawn from the research are provided, along with its contributions. A new approach to workplace stress is presented, based on both the literature and empirical evidence. Previous findings suggest that workplace stress is an isolated phenomenon. However, the empirical material from this study suggests that workplace stress is a combination of different domains which cannot be studied in isolation. It also highlights that stress is not limited to specific occupations or professions, or income or household levels.

There are two main original aspects of this research, making a further contribution to the body of work on work-related stress. One is that it does not only address the narratives of one type of occupational group or hierarchical level as most workplace studies do; rather, it takes into account narratives provided by other groups such as HR staff, occupational health staff, union representatives and line managers, including qualified clinical nurses. The other is that it has been carried out by a mental health support worker who continued to work in this role throughout, rather than by an academic researcher situated within the hierarchical structure of a university organisation. This therefore provides an insight into the depth of working experiences of mental health support workers.

Chapter 9: Conclusion

The final chapter draws together key important contributions and discussion points from across the findings. It discusses the implications for academic literatures, the practical implications for the NHS as an organisation, and the implications for managers and policymakers, including key questions raised and recommendations for future research. It also provides final reflections.

1.7. Concluding Remarks

This introductory chapter has set the scene for the research, positioned it within the relevant context and provided the research's aim, significance and statement of topic. It has portrayed work stress as being widespread among NHS staff, leading to increasing levels of sickness absences, which are currently higher than average compared to other job sectors in the UK. It has also highlighted the contextual backdrop for an ethnographic study of work-related stress among mental health support workers and outlined the motivation behind the research and choice of subject, the purpose of the thesis, and the gap in theoretical, empirical and methodological research on work-related stress among mental health support workers.

Chapter 2 will provide a review of the available academic literature relating to occupational stress in the nursing profession and among healthcare professionals.

Chapter 2. Literature Review

2.1. Introduction

The introductory chapter of this thesis laid out the contextual backdrop for a qualitative study of work-related stress among mental health support workers. It portrayed work stress as widespread among NHS staff, leading to increasing levels of sickness absences; currently higher than average compared to other sectors in the UK.

This chapter draws on prominent studies within the sociology of stress to articulate the dynamics of the stress process in the construction of a sociological paradigm aimed at increasing the understanding of stress and work-related stress among healthcare professionals in the NHS which underpin this study. Conceptual issues and existing studies on work-related stress are reviewed and the various theoretical and conceptual perspectives underpinning previous stress literature are discussed. The different strands of literature discussed in this chapter were identified through a structured process that began by searching different databases and conducting electronic literature searches; for example, EBSO, Medline, Scopus, and library search including Google Scholar. I also conducted manual searches relevant to occupational stress and sickness absences at an NHS library in Newcastle.

I begin the literature review by looking at the definition of stress and the main conceptual and operationalised perspectives on this phenomenon. This discussion also includes examples of perceived workplace stressors and core concepts related to work-related stress, including employee role, demand at work, work-home conflict, organisational factors, personal factors and psychological factors. I discuss theories I have used in understanding occupational stress and how this affects the organisation, and the model of stress used.

Finally, this chapter considers existing literature on mental health workers and the knowledge gap which this study attempts to address, including its limitations and critical analysis of current theoretical developments among mental health support workers. The literature review concludes with a summary of the research gaps, including key questions raised by existing literatures and a transition to the research project.

2.2. Defining stress

Stress is a contested concept, and scholarly attempts at defining it have caused substantial controversy (Cooper et al. 2007). This means that the phenomenon of stress is approached from multiple angles and through various theories.

Also, there are some debates about what stress is. A rough conceptual definition is that it is an adaptive reaction to perceived hazard or threat, which involves physical, interactive, effective and cognitive components. Similarly, one of the operational definitions of stress is as a coping mechanism that allows the individual to adapt to social stimuli that cause them pressure, fear, emotion or hopelessness within the working environment (Aiken 2011). Bodies such as the Health and Safety Executive (HSE) also provide definitions that are used in organisational practice. Where stress is prolonged, it can create psychological and physical damage and lead to anxiety and depression (HSE 2021).

However, a more comprehensive definition that works well in this study involves integrating the definitions by Anderson (2003), who states that stress is better defined as a state which occurs when a person perceives that the pressures or the demands of a situation are greater than their perceived ability to cope. This means that stress occurs when an individual is unable to cope with the perceived pressures and demands of a situation, thereby leading to fear and hopelessness within the work environment.

The difference between pressure and stress and their relationship

Scholars argue that stress can be both positive and negative; referred to as eustress and distress respectively (Tocino-Smith 2019; Mills, Reiss and Dombeck 2018; Brule and Morgan 2018; Li 2016). The literature suggests that eustress enables people to live more meaningful and fulfilled lives, because stress is a concept that is entrenched in our day-to-day lives. However, Anderson (2003) argues that there is a clear distinction between stress and pressure. Pressure can be good for the individual; there are times when we have all been under some kind of pressure and some people will say this kind of pressure motivates them to give their best performance. But when the pressure becomes unmanageable and the person no longer has the capacity or the

resources to cope with the demands, this leads to stress, and stress is never a good thing.

Outcomes and implications of stress

Stress is a helpful concept that is meaningful to people at work, even though from an academic point of view we might call it something different; but it has been used very widely and is therefore regarded as an encompassing term. A stressful workplace leads to increased rates of absenteeism, high employee turnover and increased costs, which can come from training staff replacements for sick leave, compensation claims and wasted investment in training (Mark 2008; Foy 2015). Efforts to minimise stress and thereby maximise job satisfaction will largely depend on contextual findings because different stressors require different actions. Furthermore, an understanding of the possible causes of stress may help management to achieve possible ways of minimising its negative consequences (Fulcheri et al. 1995). Also, more insights into the causes and consequences of stress will provide opportunities to develop interventions that prevent and address stress in nursing staff (Hazelhof et al. 2016).

It has also been reported that increased levels of work-related stress are linked to poor health, thereby leading to physical and mental health problems for hospital employees (Mark 2008; Mosadeghrad 2014). Other outcomes include insomnia, changes in mood, frequent exhaustion, inability to concentrate, and changes in health-related behaviour which may lead to increased use of alcohol or drugs, drinking and smoking. Scholars have analysed the issues listed above and found associations between such stressors and various strains, suggesting that as stress increases, there is a likelihood of job dissatisfaction and lack of motivation (Zaleznik et al. 1977). Many researchers and medical professionals now believe that too much exposure to stressful conditions and activities can lead to a number of disorders and diseases which can affect an employee's physical health, putting them at risk of cardiovascular diseases such as hypertension, musculoskeletal pain and exhaustion (Donaldson-Fielder et al. 2011).

Stress has also been clearly linked to the digestive system and increased susceptibility to diseases such as cancer (Looker et al. 2008); risks to psychological

health, including mental health problems such as anxiety; loss of humour and concentration; depression; reduced self-esteem; moodiness and loss of confidence (Donaldson-Fielder et al. 2011). Other examples of stress-related disorders include diabetes, migraine, rheumatoid arthritis, cramps, headaches, constipation, overeating, increased cigarette consumption, caffeine intake, sexual disorders, anorexia and increased alcohol intake; these are classed as health behaviours (Donaldson-Fielder et al. 2011; Looker et al. 2008).

Apart from the health implications of stress listed above, an employee may start to experience working health, an impact on the psychological contract which affects the existing relationship between the employee and the employer. This may result in feelings of unfair treatment, lack of commitment and engagement (Donaldson-Fielder et al. 2011). Also, there is a chance the individual will start to have social and relational-health issues, which might lead to a lowered desire to engage in social interactions, becoming irritable at the slightest provocation, and snappiness. All this may lead to a breakdown in relationships with others (Donaldson-Fielder et al. 2011).

The stressors that are predictive of job dissatisfaction indicate a correlation between the dimensions of workplace and stress, leading to a greater tendency to leave the organisation (Hoboubi et al. 2017).

2.3. Key theories of stress

Various theoretical positions have been explored by scholars to explain the concept of stress and its causes. Most theoretical explorations have been towards an examination of the divide between the individualistic epistemology (Folkman and Lazarus 1984; Jick and Payne 1980) and the environmental theoretical concept (Karasek 1979; Karasek and Theorell 1990; Siegrist 1996). This means that stress can be based on the shared interaction between the individual and the environment (Kerdijk et al. 2016). The difference between the two perspectives is that while the former focuses on the individual's ability to cope with stressful situations, the latter focuses on the specific environmental risk factors that can lead to the development of stress. The two theoretical perspectives present opposite phenomena to the concept of stress by

creating an imbalance between individualism/subjectivism and objectivism (Kierkegaard et al. 2015).

The major contemporary theories in the scientific literature help to clarify the causes and mechanisms underpinning occupational stress. Many of these theories have been adopted to guide interventions. Three structural models that help to describe key variables in relation to outcomes are the Person-Environment Fit theory (P-E Fit theory), Job Demand-Control (Support) theory and the Effort-Reward Imbalance Model (ERI model). Four of the theories listed in Table 2.1 below are particularly influential in the study of stress in the workplace: the Transactional Model (Lazarus 1991), Conversation of Resources theory (Hobfoll 1989), Effort-Reward Imbalance theory (Siegrist 2001) and the Demand Control Model of Job Stress (Karasek 1979).

Table 2.1. Stress Theories

Stress theory	Application to the concept of stress
Response-based theory (Selye 1976).	This theory proposes the consequences of diverse types of stimuli resulting in the same physiological responses.
The general adaptation syndrome (Selye 1983).	This theory proposes that an event (a stressor) that threatens an organism's wellbeing leads to a three-stage body response: Alarm, Resistance and Exhaustion.
Stimulus-based model (Holmes and Rahes 1976)	This proposes that lives change as a result of stressors, which can be either positive or negative, and this can cause

	both physiological and psychological strain that can lead to ill health.
Transactional-based theory (Lazarus 1991)	A theory of work-related stress which posits that there are two aspects of stress, including cognitive appraisals.
Conversation of resources theory (Hobfoll 1989)	Hobfoll suggests that a worker is affected by physical, psychological, environmental and organisational factors.
Effort-reward imbalance theory (Siegrist 2001)	Focused on the psychosocial dimension of human health and wellbeing.
Demand control model (Karasek 1979).	Illustrates the variation between demand and control and its impact on stress levels amongst workers.
Stress and coping theory (Folkman and Lazarus 1988)	Provides a framework for testing hypotheses about the stress process as it relates to physical and mental health.

Contemporary theories of stress help us to understand the construct of work-related stress and to view it as an active collaboration between the individual and the environment. In addition, the stress process has been conceptualised in diverse ways, especially in terms of occupational stress research which ranges from simple theories that place emphasis on different work conditions to complex theories that conceptualise stress into different stages (Mark 2008). These theories implicitly or explicitly help us to recognise the psychological processes, which may be emotion, cognition and perception (Griffiths et al. 2010). They also help us to understand how the individual recognises and responds to stressful conditions, how they attempt to

cope with that experience and how this might impact on their social, physical and psychological health.

In order to reconcile the gap between the individual and environmental approaches, Kiekegaard and Brinkmann (2015) propose a collective and distributive stress concept of how employees cope with stress and the coping strategies the environment offers. Such concepts include the Effort-Reward Imbalance Model, which predicts that employees experiencing high job demand with insufficient job resources to handle such demand can end up with stressful conditions (Loerbroks et al. 2016), and the Work Environment Model, which states that an environment where collaborative activity takes place is as important as the physical environment in a workplace (Hua 2010).

Conversation of Resource (COR) theory (Hobfoll 1989) suggests that stress in the workplace occurs from losses of resources, especially after the individual had invested in such resources. Hobfoll divides resources into four:

(i) Objects, such as properties and vehicles.

(ii) Energies, such as money, time and credit.

(iii) Personal Characteristics, such as self-esteem and skills.

(iv) Conditions, such as status and job role.

Thus, a worker is affected by physical, psychological, environmental and organisational factors. Theorists suggest that the possession or lack of one or all of these factors can be the difference between motivation and stress in the workplace (Schaufeli et al. 2004; Hochwarter et al. 2007).

Effort-Reward Imbalance (ER1) theory (Siegrist 2001).

According to this theory, the personal self-regulation of an individual is important for his/her health and wellbeing. Individuals engage in appraisal of social exchange from time to time. The kinds of responses they get from such appraisals determine to a large extent the kinds of emotion they express. The implication of Siegrist's theory is that individuals want to be valued by what they give out. However, when there is no value

or rewards in social exchange/reciprocity, negative emotions are elicited, leading to sustained stress (Meurs et al 2011; Preckel et al. 2007; Siegrist 1996).

The *Demand-Control Model* was introduced by Karasek (1979). When workers have high controls, they experience low levels of strain their demands at work are low, and vice versa. Control is in fact an important resource that helps individuals decide whether they have the necessary tools to deal with demands at work (Meurs et al. 2011).

All these theories of stress help us to understand the construct of work-related stress and to view it as an active relationship between the individual and the environment. These theories implicitly or explicitly help us to recognise the psychological processes, which may be emotion, cognition and perception (Griffiths et al. 2010), and to clarify the causes and mechanisms underpinning work-related stress. They also help us to understand how the individual recognises and responds to stressful conditions, how they attempt to cope with that experience and how this might impact on their social, physical and psychological health.

Transactional Model and approach to stress.

Although many of the theories discussed above have been adopted to guide interventions, within the context of this research, the transactional model appears to be considered particularly relevant to draw on to address the research gap. This is because this model explores the interactions or transactions between the person and their environment; in this case mental health support workers and their environment (e.g. workplace and organisational) over time through their re-appraisal of the situation and this makes it a reflexive process. In addition, Arthur (2004) suggests that work-related stress is relational involving some transaction between the individual and the environment. This means that stress is the direct product of this transaction and could impact on available resources thereby threatening an individual's health and wellbeing (Folkman and Lazarus 1988). Therefore, any aspect of the work environment can be perceived as a stressor and the experience of workplace stress can be associated to

exposure of certain workplace scenarios and a person's attempt to cope with the underlying problem (Pezaro 2018).

Stress and coping are interrelated concepts (Melnyk 2011), and applying theories of work-related stress to experiences would allow for an understanding of both the personal and the environmental constructs of the stress process (Mostafa 2020). The seminal work of Folkman and Lazarus (1984) provides different conceptual categories such as avoidance, emotion-oriented coping and problem-oriented coping which frame the stress-coping relationship. In addition, by looking at organisations that acts as resources for people in terms of stress, we can apply these conceptual categories and ascertain their validity and explanatory potential. The NHS is an example of such an organisation (Melnyk 2011).

In addition, the transactional model considers both the individual's physical, biological and psychological experiences of stress as well as the impacts of their stress and coping mechanisms. Stress is universally understood to have a negative impact on an individual's wellbeing (Melnyk 2011). However, coping is understood to be a protective measure against internal and external demands perceived as stressful (Melnyk 2011). Lazarus's definition of stress: when people perceive that they cannot adequately cope with the demands or threats to their wellbeing, meets the aim of acknowledging the importance of the wider contextual conditions and the individual experiences of stress (Mustafa et al 2020). Following this premise, it is sensible to expect that stress levels predict coping behaviour; however, this has not been the case from previous empirical studies (such as Connor-Smith and Compas 2002; Billings and Moos 1981). Instead, these studies have found that the function of coping is to manage stressful situations in order to produce more beneficial health outcomes. Thus, understanding both the individual aspect of stress and wider factors as situational demands, previous experiences, coping skills and any current stress already experienced is paramount to understanding stress experiences.

The transactional model implies that stress neither relies solely on the individual nor on the environment but on the transaction between them (Lazarus 1999). Thinking of stress as a transactional term (Lazarus 1990, 1999; Lazarus and Launier 1978), it is considered that no one component can be said to define it as it becomes part of the content in which the stressful encounter emerges (Dewe et al. 2012). According to

Lazarus and Folkman (1984), stress is a relationship between the person and their environment and is appraised by the person as exceeding their resources to cope and thereby endangering their wellbeing (Berjot and Gillet 2011). Also, stress is conceptualised in this model as the incongruity between the perceived demands of a situation and the person's resources to deal with this demand (Au 2016). In essence, Lazarus (1991) suggests from this theoretical point of view that when there are primary concerns in the workplace, events or demands supersede the available resources to cope; this leads to strain and eventually stress occurs.

This framework lays emphasis on two core concepts: cognitive appraisal and coping appraisal (Folkman 2013). The cognitive appraisal consists of evaluating whether events in the workplace are deemed a threat to an individual; the coping appraisal evaluates whether anything can be done to cope with stressful events in the workplace. This is important and relates to the study because the transactional model provides a broad consensus that stressors exert their effects through how an individual evaluates and perceives them. Also, understanding both the individual aspect of stress is key to understanding stress experiences (Mostafa 2020).

Lazarus (1999) makes a clear distinction between social stress, physiological and psychological stress. This is accomplished by integrating both stress and emotion into one theoretical framework using appraisal and coping as its basis. This framework according to Williams and Williams (2022) suggests that coping needs to be presented in a more pragmatic way as two subcategories known as negative-reactive coping (negative emotion focussed) and positive cognitive coping (problem focused and positive emotion focused). The authors argue that although this can be conceptually different, it is however easily understood. However, a particular criticism of stress and coping research is that there is often a lack of applied research that puts theory into practice (Mustafa et al. 2020). Also, attempts to 'fit' individuals to cope with the demanding nature of work and practices cannot effectively deal with the overall increasing levels of stress (Arthur 2004). Rather, an integrated approach from communities and occupational health specialists aimed at acknowledging how social, economic and organisational factors impact on the needs of an individual is needed (Arthur 2004).

However, applying this theory to stress experiences would allow for an understanding of not only the personal factors but also on the environmental elements of the stress process. By looking at organisations that act as resources for people when in need and during stressful conditions, we can apply this theory and ascertain the benefit in developing a more holistic understanding experiences of stress.

The sociological study of stress

Many stressful experiences can be typically traced back to surrounding social structure and people's location within them (Pearlin 1989). As such, most research into stress starts with an experience that people are faced with and their perceptions of that constraint which could either be burdensome or threatening (Pearlin 1989). These experiences may result in stress; therefore, the structural contexts of people's lives are fundamental to the stress process.

The stress model in sociology has developed continually to reflect changes in society (Au 2016), recognising that every individual is inevitably immersed in a social environment comprised of different social settings that require interactions with work, family, friends etc. (Au 2016). Therefore, stress occurs in an instance where the relationship between the individual and their environment suffers from a lack of congruity. In other words, stress was defined by Aneshensel (1996) as a state of stimulation due to the presence of socio-environmental demands that overpowers the adaptive capacity of the individual. The essential element of the sociological study of stress can be demonstrated through the presence of similar levels or types of stress of people who are exposed to similar social conditions, roles and who come from similar situational contexts (Pearlin 1989). Therefore, a prominent feature in sociological stress research is its socially patterned distribution of components of the stress process and such patterns provide a cue that people's potentially stressful situations and experiences and the ways in which they are affected by these experiences may originate within the social orders that they are part of (Pearlin 1989).

Extant research suggests that there are different levels of stressors, different conceptions of stressors and different effects of stressors including role, resources, and categories of social support (Pearlin et al 1981; 1997). Continuous and discrete

stressors are not mutually exclusive; rather one stressor can actually establish the other, for example life events. This means that troublesome elements of everyday life are in themselves chronic stressors drawing to attention a level of social reality often ignored (Aneshensel 1992). Also, life events can cause stress that alters the role of an individual; for example job loss or threat to job can cause stress for an individual, but this may become more prominent if they have parental responsibility to provide for their children and family (Au 2016).

Also, enduring roles such as an occupational role also reflect larger contexts where the consequences of values and social status in an organisation are revealed through how people are affected by their jobs (Au 2016). Therefore, the theoretical perspective of viewing roles as 'contexts' calls attention to social status which exists as not only as an attribute of the individual but can also be conceptualised as part of 'contextual social inequality as existing across multiple layers of the social hierarchy' (Aneshensel 2010;35). Social consequences of stress can include six forms of role strains such as problems between individuals and nature of tasks, multiple roles, role captivity, gain/loss of roles, interpersonal problems, intrapersonal problems and role reconfiguration (Pearlin 1983). Also, work-related stress reflects psychosocial difficulties of an occupational, socio-economic and individual nature which can impact negatively on health and wellbeing.

In summary, this section has critically examined the core concept of this study, the debates about what stress is and how stress can be studied. It also highlighted the different theories of stress and appraised the Transactional Model of Stress and Coping and explored the sociological study of stress, social consequences of stress and the differences between stress and pressure. The section thus acknowledges the complexity of work-related stress and critiques the use of mono-theoretical models and simplistic solutions to tackle it. The next section will focus on stress as a multifaceted phenomenon and describe in more details stress within life, organisational and work domains.

2.4. Stress as a multifaceted phenomenon

The socially constructed nature of stress implies that it is about how people experience and make sense of it; also, when the demands continue for any length of time without respite, then physiological, psychological and behavioural problems may arise (Anderson 2003). However, stress is not a one-dimensional construct and can be operationalised differently (Smyth et al. 2013). A person can be exposed to events called stressors. They can assess how much they feel threatened by these stressors – this is called appraisals; and they can respond to the demands of the situation – this is called perceived coping (Zawadzki, et al. 2022).

Due to the multifaceted nature of stress as discussed above, it is extremely difficult not only to measure but to compare across different population groups. Although there is a long history of measuring the association of stress and wellbeing, it is difficult to compare, for example, chronic versus acute stress (Zawadzki, et al. 2022).

In recent decades, the nature of work has been changing in economically developed and developing countries; this includes changed organisational work patterns which cover new ways of working and flexible work patterns (De Jonge et al. 2017). Nowadays, occupational stress, which is a subset of work-related stress associated with a specific profession, has become more of a mental and emotional issue for employees rather than a physical one.

Different occupations have their own specific stressors that are intrinsic to the nature of the job; for example, caring for ill people where there are limited resources in healthcare settings. These stressors may be personal: entrapment in the job, financial burden (Kulkami et al. 2014), limited access to healthcare facilities and shortage of trained healthcare workers (Abbas et al. 2017). There are also correlations between observed stress and certain working characteristics, including the number of hours worked, lack of support at work from employers, demanding working environments and exposure to certain physical agents. Those reporting to be highly stressed are seen to have health problems and to be prone to accidents at work (McKay et al. 2006).

There is a widespread consensus that certain aspects of work can lead to stress, such as excessive work demand, limited information and support from

management, organisational changes, career development and work-home boundaries (Watson and Reissner 2022; Looker et al. 2008; Donaldson-Fielder et al. 2011). In addition, there appears to be a loose consensus on the nature of stress, as well as factors that contribute to stress within the workplace (Cox et al. 2000; Cox 2004; Hoel et al. 2001). The nature of work-related stress is such that tension and pressure impacts on individuals; the contributory factors are inability to cope with the demands of the job, lack of control over the way that people do their work, lack of role clarity and responsibilities, relationship breakdown at work, and non-engagement during times of change (Keller 2012; HSE 2021).

Similarly, several researchers have tried to identify sources of work-related stress; their results suggest that extreme workload, poor pay, challenging patient behaviour, tough working conditions, uncertainty concerning treatment of patients and several occupational health and safety hazards are stressors in the work environment (Mosadeghrad 2014). People may experience stress in different life domains and also at different levels of the workplace. Major life events such as changing jobs, getting married or divorced, raising a family, dealing with the death of a friend or loved one and suffering from chronic diseases are all stressors that can impact the foundations of one’s life and play a significant role in personal upheaval (Keller 2012).

2.4.1. Stress in the life domain

Stress can result from pressures in people’s private lives (Walonick 1993): lifestyle, financial status, physical and emotional status are perceived as determinants of the levels of stress and changes an individual faces (Boyaci et al. 2014). Times of change and uncertainty and issues of personal boundaries or the lack thereof can magnify our personal stress (Keller 2012). These boundaries include but are not limited to work, home, eating habits and relationships.

Conceptually, personal stress can include stressors from the home environment, relationships, and health concerns for oneself or loved ones (Khamisa et al. 2017). Other examples of stress that people experience outside the working environment include the deaths of loved ones, financial strains, and marital issues, for example divorce (Holmes and Rahe, 1967; Dohrenwend and Dohrenwend, 1967;

Bartolome et al. 1979; Burke et al. 1980). It has been argued that although stress has become an organisational issue, the solutions put in place tend to be individual, even though studies show that environmental changes are more successful (Baehler et al. 2008).

The health and wellness of an employee are very important, both for the individual and the employer (Tetrick et al. 2015): individuals who are stressed at work are likely to be less productive, less safe at work and poorly motivated (Leka et al. 2004). Stress in the individual can also lead to silent heart attacks, angina, and changes in levels of cholesterol. The involvement of the stress response in circulatory diseases such as coronary heart disease, hypertension and stroke can lead to sudden cardiac death. These diseases often result from interactions with other factors such as smoking, diet and type A behaviour (Looker et al. 2008).

When affected by work stress, individuals can become distressed, anxious, tired and depressed; they may lose concentration and have difficulty in thinking logically and making decisions. Stress is seen as a psychological factor (Gates et al. 2011) contributing to lack of sleep, commonly referred to as insomnia; anxiety attacks and low self-esteem (Jones and Lyneham 2000). Psychological factors such as reduced commitment to work or the organisation, increased psychosocial distress and decreased job satisfaction are perceived as psychological stress (Demir and Rodwell 2012). Feelings of sadness, anger, shock, confusion and embarrassment are also perceived as psychological, and these can lead to stress. Apart from these health implications, an employee may start to experience working health, which is an impact on the psychological contract. This affects the existing relationship between the employee and the employer, which may result in feelings of unfair treatment, lack of commitment and disengagement (Donaldson-Fielder et al. 2011).

As discussed above, work stress is universally recognised as a major challenge to an employee’s health, affecting people in different ways along with the wellbeing of their organisation (Leka et al 2004). Furthermore, findings from recent research see personal stress as a predictor of burnout and hence negatively affecting job roles (Khamisa et al. 2017).

2.4.2. Stress in the work domain

Work-related stress is seen as a negative employee outcome (e.g. Mostafa 2016). Organisational stressors are termed an inevitable part of an organisation which cannot be overlooked, and efforts can be made within the organisation to reduce the consequences of work-related stress (Jain et al. 2013). Examples of such stressors include high expectations from the job, lack of time, lack or imbalance of skills, demands from work and lack of social support (Ruotsalainen et al. 2015). Others include the organisation's style of management, organisationally induced work stressors such as role conflict, lack of control when deciding how to complete certain tasks, lack of clarity of job roles or role ambiguity (Deondra et al. 2005), and health policies implemented in recent years (Boyaci et al 2014).

On the management side, the mental and physical effects of work-related stress are not the only disturbing influences on managers today; they also face numerous challenges in the task of managing their employees to deliver high-quality services. Frontline managers, especially in the nursing profession, have a very important role to play in healthcare settings; they are also faced with significant job-related issues in an otherwise challenging and constantly changing healthcare environment (Adriaenssens et al. 2017). On the other hand, the HSE states that poor management behaviour is often highlighted as a major factor by employees suffering from work-related stress; it has therefore designed a series of tools allowing managers to assess whether they currently have the behaviours identified as effective for reducing and/or preventing stress in the workplace. These are behaviour and competency tools which help managers to assess how they manage the individual within a team, reasoning and managing difficult situations, managing emotions and communicating existing and future work to employees.

From recent studies, the supplement to a workplace intervention is a rationale for training supervisors and line managers on the issues of stress management at work (Horan et al. 2018). There are several reasons why managers should be alert to work-related stress (Baehler et al. 2008) including the possible effects on employee satisfaction, performance, wellbeing and productivity. On the other hand, healthcare managers in a government-run organisation are expected to have the capability to balance between conflicting political, social/relational and organisational demands

(Lornudd et al. 2016). Hence, effective management has been suggested to be the best form of stress prevention at work (Leka et al. 2004). Prevention is the desired goal in managing workplace stress. However, because organisations are different, the sources of stress may be specific to the particular organisational context and the wider environment. For example, stressors in an extractive industry are different to a professional service; therefore there is no “one shoe fits all” approach to managing work-related stress (Parkyn and Wall 2020).

Currid (2009) suggests that staff in mental health services often face violence and aggression from patients; as such, even when they return home, they are unable to switch off from work, which could result in stress. This causes spill-over of stress from work to home. Although it has been recognised that personal stress can spill over into the work domain (Khamisa et al. 2016), much of the extant research treats work-related stress in isolation (Khamisa et al. 2016). This is problematic because stress at work does not happen in a “vacuum”; it is described as a multifactorial phenomenon, meaning that problems at home often overflow into how a person performs at work (Chambers et al. 2003).

At the individual level, stress can have negative consequences such as impacting motivation, career progression and life and job satisfaction (Stevenson and Farmer 2017). As stress is socially constructed, some people experience and interpret stressors as normal parts of home or work life, whereas others can get really ill when faced with similar stressors. However, within this lies individual variations in adaptation; people may have different abilities with regards to coping with these stressful conditions both at work and outside of work (Caplan et al. 1975). This can be likened to the way people deal with stress in terms of resilience and cognitive appraisal (Lazarus et al. 1978).

2.4.3. Stress in the organisational domain

One of the implications of stress leave in an organisation is its organisational cost; workers may take sick leave and may even change jobs (Ruotsalainen et al. 2015). The impact of stress on the organisation can be measured in the following ways:

- Absence: Sickness absence is regarded as one of the most significant costs of occupational stress and is also very palpable in terms of calculation (Hassard et al. 2014)
- Presenteeism
- Turnover
- Hidden costs
- Accidents and injury and decreased productivity

Where many members of the workforce are suffering from stress, this may not only cause the organisation to be inefficient but also cause organisational problems such as poor productivity, accidents, thefts and poor management which includes resistance to change, poor decision making and lack of job fulfilment for staff (Chambers et al. 2003). Because the employer-employee relationships is a human relationship and emotions are a fundamental and important part of it, problems arise when organisations fail to take account of the 'elements of self' which employees bring (Herriot 2001, p. 179).

Additionally, stress can have an impact on one's productivity, health and even emotions; thus, it has to be brought under control. Stress can also impact on organisational welfare and on personal supervisors and employees (Mirela and Madalina-Andriana 2011).

From an organisational point of view, although few organisations acknowledge their position fully in helping employees to cope with work stress and organisational change, there are a number of initiatives and strategies that can be adopted. These involve adopting a well-defined organisational culture which includes adequate communication, appropriate leadership and stress management programmes (Callan 1993). An organisation that has systems for providing regular and sustained levels of support to staff will be more effective and less likely to suffer the effects of stress (HSE 2009). A study by Jick and Payne (1980), for example, highlights three strategic ways of dealing with stress in organisations:

1. Treat the symptoms
2. Change the person

3. Remove the cause of stress

However, this simplistic view of the causes and manifestations of stress can be critiqued: it could be argued that it is not that easy. Whilst Jick and Payne's theoretical standpoint seems effective, it could be that these strategies will be counterproductive because, firstly, there will most likely be multiple and conflicting symptoms. In other words, if you address one symptom, you will trigger another. Secondly, why should a person change? And in what way? Admittedly, a certain degree of resilience and ability to deal with stress will be present in everyone but there will be significant differences in people's ability to deal with stress. Instead, it should be about giving people the resources to be more resilient and deal with stress more effectively. Thirdly, this notion sounds as though organisations deliberately do not remove the causes of stress. However, some scholars argue for more substantive organisational change to reduce stress at work (Cooper et al. 2007). Alongside issues of pay, communication and development opportunities should be addressed as these could lead to lower levels of job satisfaction from employees if ignored (Pate et al. 2000).

Literature indicates that environmental changes are more successful for reducing stressors than encouraging individuals to take better care; this therefore suggests that practical interventions that focus on work organisation, culture and relationship management may be more productive to yielding meaningful results (Baehler et al. 2008). Baehler et al. (2008) believe that the organisation can cause stress and at the same time play a role in improving it. They emphasise that management should be keen to take steps to review current organisational practices.

Stress can also impact on organisational welfare and on personal supervisors and employees (Mirela and Madalina-Andriana 2011); hence, lack of control and lack of decision making can be classed as organisationally induced stressors. In addition, Bacharach et al. (2002) establish that discrepancies between employee expectations and capabilities, coupled with organisational policies and expectations, are seen as work-stressors. Barley et al. (1992) therefore suggest making organisational expectations clearer and engaging in stricter policy implementation as a solution to improving stress in the workplace. Although few organisations acknowledge their position fully in helping employees to cope with work stress and organisational change, there are a number of initiatives and strategies that can be adopted; this involves

adopting a well-defined organisational culture which includes adequate communication, appropriate leadership and stress management programmes (Callan 1993).

Ineffective management of stress at work and continuous sickness absence at work both have serious implications for the organisation, including direct and indirect costs (Hassard et al. 2014). Direct costs include replacement of labour (use of agency staff), absent employees' salaries, and overtime pay for other staff covering for absent leave. Indirect costs include additional stress on staff covering for sick staff, reduced productivity and worsened customer service because replacement cover may need to learn about the work, and also training and support to other staff. These problems are leading the government to create legislation related to work stress for the protection of employees. It is therefore suggested that managers and employers are aware of what stress is and how it might look for others; they are putting in place processes aimed at spotting its signs and symptoms within the organisation, using training programmes, factsheets and briefings. Managers are also encouraged to include regular work planning sessions and engage in team meetings, informal chats and appraisals (Donaldson-Fielder et al. 2011).

Dall'Ora et al. (2016), in their literature review on the characteristics of shift work and their impact on employee performance and wellbeing, identify the effect on employee performance (including job performance, productivity, safety, quality of care delivered, errors, adverse events and client satisfaction) and wellbeing (including burnout, job satisfaction, absenteeism, intention to leave the job) in all sectors, including healthcare. They therefore emphasise the need for future research to focus on the impact of shift roster. Furthermore, more insights into the causes and consequences of stress will provide opportunities to develop interventions that prevent and address stress in nursing staff (Hazelhof et al 2016). Once stress is recognised as a genuine and necessary concern for the organisation, this raises the subject of the delivery of support within that organisational contest (Arroba et al. 1990). Organisations should therefore ensure that there are people who are recognised as having the necessary helping and counselling skills to provide support to employees through stress management training.

Management style

In the healthcare profession, as with all other occupations, line managers have a significant role to play in not only identifying stress at work but reducing it. However, managers should also reflect on their own behaviour and how this may contribute to or help reduce work-related stress issues. For example, if the root cause of stress is excessive work demand, managers can review the person's workload, delegate some tasks to other staff members, or bring in new staff either through recruitment or the use of a temporary bank or agency staff (Watson and Reissner 2022). Similarly, if the cause of stress relates to interpersonal relationship issues, then enabling staff to rotate or change teams may be an appropriate organisational response (Watson and Reissner 2022).

In addition, ability to manage employees has been suggested to be the best form of stress prevention at work (Leka et al. 2004). Work ability index (WAI) is a tool used in occupational health for assessing work ability during workplace surveys. The index is determined by the answers to a series of questions considering the demands of work, employees' health status and the resources available (Ilmarinen 2007).

According to a recent study, employees were seen to be more likely to report job-related stress than managers (Mosadeghrad 2014). Sugimura and Theriault (2010) hypothesised that the support of a manager influences the work ability of workers, and this support is associated with questions that not only help to assess work demands but also a worker's resources. Therefore, management should provide regular clinical supervision for staff, including treating them fairly (O'Connor et al. 2018).

Furthermore, it is vital for managers to understand work-related stress and poor health as these relate to the organisation as a whole, and interventions to manage pressure at work should be implemented throughout healthcare organisations (Chambers et al. 2003). This research further suggests that in order to do something positive about the causes of stress at work, from the manager's perspective, it is very important to be able to identify such sources.

Also, Smollan (2017) identifies that support both from inside and outside the organisation helps employees to cope with work-related stress. This study reveals that such support takes various forms: appraisal, emotional, informational and instrumental.

Hence, barriers to accessing and providing support to employees need further exploration (Smollan 2017). In many jurisdictions, there are now compelling legal incentives for employers to identify and manage potential workplace stressors, thereby reducing the incidence of work stress (Baehler et al. 2008). The HSE has addressed the problem of stress by developing Management Standards to help employers measure their performance, manage the key causes of stress at work and hence identify areas that need improvement (HSE 2021). These standards look at the demands placed on employees, the level of control employees have over their own work, the support employees receive from managers and colleagues, the clarity of an employee's role within the organisation, the nature of relationships at work and the way that change is being implemented.

Work environment

Geuens et al. (2016) state that healthcare professionals are exposed on regular basis to environmental stressors such as death, pain, suffering and ethical issues. Work-related stress is capable of influencing healthcare professionals' physical and emotional wellbeing by curbing their efficiency, thereby having a negative impact on their overall quality of life. It is therefore important to find strategies for employees to cope with the negative consequences as a result of stress at work (Koinis et al. 2015).

Roche et al. (2010) find out that there are significant differences in the work environment between nurses in mental health and their colleagues on the general side of nursing. Research has also established that certain factors in the work environment influence not only nursing but patient outcomes (Rafferty et al. 2007, Cheney et al. 2008). These factors include adequate flexible staffing, access to resources, organisational support, professional autonomy and collaborative relationships (Roche et al. 2010).

However, Mann et al. (2005) argue that many of the sources of stress in mental health settings are not directly related to the intrinsic caring nature of the job. There are organisational factors which include shift patterns, uncertainty in the job, essential mandatory training and keeping up with the nature of the job. It is important, however, to consider the emotional requirements of the job: the concept of emotional labour

comes into play. This concept describes what workers do that goes beyond their cognitive duties, thus suppressing specific emotions in the care that they provide to others and in so doing adding value to their organisation (Webber 2012). It also describes the management of emotions in the organisation and the emotion management skills which organisational actors such as mental health support workers need to possess to achieve organisational objectives whilst also acknowledging the subjective experiences of members (Bolton 2005). Such emotional display often leads to workplace outcomes such as poor wellbeing, poor health, poor performance and reduced job satisfaction (Mortensen and Needham 2022).

Workplace stress has become an increasing area of concern (Kipping 2000). Until the 1990s, just a few studies had investigated workplace stress amongst mental health nurses. As clearly identified from studies, mental health professionals, even though they may be subjected to the same organisational stressors as other staff, also face additional strain from the nature of their profession in dealing with troubled persons over a long period of time (Moore and Cooper, 1996). From studies, several mental health nurses were noted to be facing pronounced levels of stress that were triggered by lots of complex processes which resonated at individual, organisational, interpersonal and the wider societal levels (Kipping 2000). Due to these increased levels of stress, their coping strategies often aggravated stress rather than reducing it. In this instance, negative assessment of one's ability to deal with stressful situations can sometimes exacerbate perceived stressful actions (Orzechowska et al. 2013).

According to the World Health Organisation (WHO), "a healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace" (WHO 2012:14). It is well documented that the nursing environment is a very stressful working place (Humpel et al. 2001), and even though mental health workers perceive their work as meaningful and important, it is regarded as often very demanding with mental health nurses describing their experiences of their role as vague and unclear (Holmberg et al 2018). Tully (2004) while reviewing stress amongst psychiatric nurses also advocates that the nursing profession is indeed a very stressful one. In addition, the healthcare profession is ranked as among the six

most stressful professions, although not all healthcare professionals develop the same level of stress (Koinis et al. 2015).

Therefore, working within a healthcare environment requires employees to deal with very demanding situations at work; the everyday pain, suffering injuries, increased workloads, long shifts, lack or insufficient number of staff and excessive pressure make healthcare one of the most stressful spheres (Koval 2016). Mosadeghrad (2014) therefore suggests that further research involving hospital employees is needed to enrich the literature on work-related stress, which could generate strategies that would improve global policies for retaining employees in the healthcare profession. He also emphasises that future research should also explore the effects of variables which can directly or indirectly influence occupational stress; for example, the external environment, which could possibly be the nature of the workplace or the ward environment. I agree essentially on these theoretical standpoints and his dogmatic insistence on terminological precision; thus, it is this demand that my research answers, and as such, this thesis should be seen as an exploratory attempt that endeavours to begin charting some new theoretical terrain.

Research has linked positive work environments to better outcomes for patients and the nursing team in general nursing. In the mental health literature, such extensive research has not been carried out, but parts of these elements have been discussed when comparing nurses in general nursing and mental health settings in the United States (Hanrahan et al. 2008). There are also reports (e.g. Mental Health Council of Australia 2005) suggesting that opportunities for career developments are less open to mental health staff, and in terms of administration, management are less responsive to the concerns of mental health staff.

Previous studies have shown that the working environment in a psychiatry ward is very challenging with risks of violent patients and increased workloads (Currid 2008). Also, from recent studies (Hylen et al. 2018), there are several environmental factors that make the working environment very difficult and nursing staff have reported being frequently subjected to violent situations. It is reported that violence and aggression from patients can cause stress among mental health workers. Those who are victims of violence are often away on sick leave (Agervold et al. 2004; Currid 2008), usually due to psychosomatic and psychological stress.

In another recent study, mental health workers described their working environment and work duties as meaningful but demanding with unclear and vague roles (Holmberg et al. 2018). Mental health nursing is deemed an environment characterised by high levels of occupational stress (Dickinson and Wright 2008, Edwards et al. 2000; Leka et al. 2012), with low levels of social support (Leka et al. 2012), a higher risk of sick leave (Eriksen et al. 2003) and increased levels of burnout (Dickinson and Wright 2008) compared to other health settings such as the general side of nursing. As Edwards et al. (2000) clearly identify in their review of stress research amongst mental health nurses, their excessive level of workplace stress results from working closely and intensely with patients.

Organisational culture

Nurses are exposed to intrinsic stressors such as poor working conditions, long hours, increased workload and lack of control (Lim et al. 2010). Studies around the nursing profession have determined that undue exposure to psychosocial stressors often results in considerable job stress which results in both short – and long-term problems (Yousef et al. 2017). Nurses have been found to experience increased job stress compared to other health professionals (Khamisa 2013). In a follow-up study, Khamisa et al. (2016) discover that nurses experience higher levels of work-related stress and burnout, coupled with low job satisfaction and poor health, and this is wholly due to the nature of the work they do. For many working within the nursing profession, the job role and description involve a lot of emotional labour (Mann 2005).

In a review of stress research amongst mental health nurses, the excessive level of work stress for staff in mental health settings is usually due to working closely and intensely with patients over a prolonged period of time (Edwards et al. 2000). This brings with it the human costs of stress which are feelings of hopelessness, helplessness, depression and even attempted suicide (Tully 2004). These factors are also measured by the Nursing Work Index (NWI), which is an instrument used in assessing the attributes that define a positive work environment. However, studies of this element of positive work environment mostly focus on the medical side of nursing, generally referred to as general nursing; similar studies on mental health inpatient settings are rare (Roche et al. 2010). Mental health nurses share similar stressors with

other nurses, but the nature of mental health nursing is such that it involves close involvement with patients and their carers (Edwards et al. 2000).

Workplace practices

A recent study reveals that there is a notable lack of workplace stress management strategies amongst healthcare employees, and participants perceived this to be due to lack of interest among management (Koinis et al. 2015). This study also reveals that significant factors for reducing workplace stress include encouraging and rewarding staff morally and providing them with opportunities for further continuous education. More so, workplace stress coupled with patients' demands can be a burden on healthcare staff; hence the stressful nature of the profession (Koinis et al. 2015).

In order to try and remedy these discrepancies, Arthur (2004) suggests that an integrated approach to work stress should involve assessing the individual, their work group and the organisation itself, as the approach to work-related stress has become too basic rather than work-specific or organisation-specific. In addition, because personal stress is always carried by the employee, it needs to be catered for by the employer, especially if the manager understands the personal stressors (Docsity 2013).

Job role

Several studies have identified that working in the health service is bad for your health (e.g., Chambers et al. 2003; Mostafa 2016) and healthcare workers are known to suffer from work-related stress (Koval 2016). This is sometimes due to the fact that they may lack the time or skills to carry out their job effectively; in the end, healthcare workers may not be able to provide the high-quality services needed from them (Ruotsalainen et al. 2015). For healthcare professionals, workload and adequate staffing is their most common stressor (Koinis 2015).

In summary, the nursing profession is not a homogenous profession; hence, findings regarding stress levels in one part of nursing cannot be implicitly reflective on stress levels in a different area of nursing. Hence, stress in mental health settings must be viewed as a group of its own. Even though there are increasing attempts at

reconciling the polarised concepts of stress (Kiekegaard 2015), as discussed in the previous section, current theories about stress may not adequately explain stress among mental health support workers, or why working in mental health as opposed to the general side of nursing is fundamentally different. In mental health settings, the work environment is different from the general side of nursing in terms of the kind of patients admitted and their diagnoses. In contrast to mental health patients, there is less risk of violence and aggression from patients admitted to general nursing. Although mental health nurses share many of the stressors of other nurses, the nature of mental health nursing is such that it necessitates intense personal involvement with patients and their carers (Edwards et al. 2000).

2.7 Rationale for the study

We have learned important insights from the studies that have been highlighted and reviewed in this section. For example, how work-related stress may be mainly due to organisationally induced stressors (Donaldson Fielder 2011) and environmental stressors; the correlations between observed stress and certain working conditions (McKay et al. 2006); the emotional requirements of the job, especially in mental healthcare settings (Mann et al. 2005); and certain aspects such as the work-home boundary (Looker et al. 2008).

However, the literature tends to look at workplace stress as an isolated phenomenon in a particular domain of people’s lives. There is a possibility that people bring stress from other domains into work and vice versa; this is what my study is attempting to address. To address this gap, I will be using a multidimensional construct by looking at the interrelationships between three domains – organisational, workplace and life – derived from this research.

In addition, although adopting ethnographic methods appears to be common within organisational research, the methods adopted by other studies have been mainly quantitative and experimental (Khamisa 2017; Conradie et al. 2017; Maguire and Ryan 2007). Therefore, within this body of research, particularly around a more holistic understanding of stress as the interplay between life, work and organisational domains, such a view of workplace stress could be critiqued from a more

constructionist paradigm which recognises that life cannot be neatly compartmentalised.

Therefore, the overarching research question in this study is:

> *How do mental health support workers experience and mitigate the impact of stress across interrelated domains: organisational, workplace and home?*

2.8. Concluding Remarks

This chapter has provided a review of the existing literature on work-related stress. A number of key findings have emerged from reviewing the literature on work-related stress in the healthcare profession and the NHS workforce. First, this chapter has underpinned the current study by considering relevant academic literatures related to the current study and providing a review of the findings and limitations of existing research on work-related stress in the healthcare sector. Second, it has detailed what has been learnt from previous research and how this current study is positioned in relation to current discussions within which the research topic is located. Third, a particular research gap was noted in relation to workplace stress, which has been deemed as an isolated phenomenon in a particular domain of people's lives. Hence, there is a recognised need for more qualitative research to advance our understanding of the complex and dynamic process of stress.

The next chapter will look at the empirical evidence that has been gathered to explore these concepts in depth and provide insights into the challenges of work-related stress both to the employee and the organisation. A qualitative, interpretive and inductive approach is required in order to obtain these insights.

Chapter 3. Methodology

3.1. Introduction

The purpose of this research is to generate new knowledge, and the generation of this new knowledge needs to be situated within a specific framework called methodology.

This chapter starts by explaining and justifying the epistemological position adopted in this study and the selected methodology and methods. It then describes and evaluates the methods of data collection, the selection process of the research participants and the approach to data analysis theorising and ethical considerations. Finally, it assesses the quality of the research.

3.2. Research philosophy

Research philosophy refers to a system of beliefs and assumptions about how knowledge is developed (Saunders et al. 2019) which affects the way a researcher will go about doing their research (Saunders et al. 2003). Engaging with an overarching philosophical stance enables the researcher to declare what they bring to the study, which will then help the reader's understanding of the origins, claims and processes derived from the findings (Harrison 2011). These assumptions are associated with the nature of reality (ontology) and subsequently the nature and justification of knowledge (epistemology) (Crotty 2008).

Research philosophy affects a series of choices regarding the conduct and evaluation of a study which enhances the understanding, explanation and development of knowledge (Sanders et al. 2015). The backdrop of this study, as an under-researched area requiring substantial exploration, was also central to the decision-making process because current theories of stress among healthcare professionals do not fully explain stress among mental health support workers. Another reason for adopting my methodology is that qualitative research complements the extant research on stress (Karkoulian et al. 2016; Erissuriz et al. 2016; Fajimoto et al. 2016).

A qualitative approach was chosen for the following two reasons. Firstly, due to the nature of the study being exploratory, directed at developing a deeper

understanding of the causes of work-related stress among mental health support workers. Secondly, work stress is not limited in scope but includes the way people experience different aspects of their lives; how different groups behave, including how interactions develop from relationships; and how organisations such as the NHS function (Teherani et al. 2016).

Therefore, the ontological position of this research is social constructionism while the epistemological position is interpretivism. The reason is that (social) reality is assumed not to exist independently of the researcher but is socially constructed; a label used by individuals to understand and make sense of their social experiences (Bryman and Bell 2007). Similarly, in order to understand a socially constructed reality, it makes sense to use methods that enable interpretation of social phenomena rather than looking for a single and fundamental truth (Grix 2002).

Likewise, an organisation is viewed as socially constructed and can only be understood from the viewpoints of people directly involved in its actions (Bryman and Bell 2007). Social constructionism conceives of reality as being subject to different interpretations of people's behaviours (Saunders et al. 2003). For example, both the interview excerpts below are socially constructed in that they refer to the same issue but in different ways:

> There is not enough resources to look after patients and this lack of resources is impacting on patient care. Patients who should be on acute wards are now admitted on rehabilitation wards due to lack of acute beds. There are less acute beds than what we had 10 years ago, and this is impacting services. It is also causing stress for staff and impacting patients negatively. – Field diary 12/03/2020
>
> For us personally, there is a lack of resource in our teams so you mentioned before when we talked about our locality and it is massive and we don't have enough intervention erhmm from ourselves, that is not from the lack of trying because we are probably working at 200% erhmm and we have to think about our own health and wellbeing but we are massively under-resourced as an HR team. – P7 05/07/2019

Social constructionism can therefore be considered a specific mode of interpretivist thought which places the spotlight firmly on the importance of interaction and social context when it comes to the construction of knowledge and meaning about the world. This provides a useful way to frame this study, given its aim to explore what causes stress for mental health support workers.

An interpretivist paradigm is closely related to qualitative approaches. It is exploratory, with flexible study designs accounting for subjective meanings and individual experience (Snape and Spencer 2003). Interpretivists assume that reality is relative and multiple, and that knowledge is socially constructed. In my research, I sought to explore the subjective meanings behind people's reported actions (Saunders et al. 2003). The value of interpretivist research is the ability to explore the specifics of a given phenomenon to understand the socially constructed reality behind it (Remenyi et al. 1998).

Most interpretivist approaches can be considered to be founded on some form of constructivist or constructionist epistemology. This is with regard to meaning and knowledge as constructed rather than discovered (Crotty 1998). In other words, constructionism refers to the construction of knowledge about reality rather than reality itself as advocated by the less widely held *subjectivist* or *radical constructivist* standpoint (Schwandt 1997; Crotty 1998). However, this constructed knowledge is not stable but is dependent on the way we view the world, which in turn is shaped by context and interaction (Patton 2002). While the terms "constructivism" and "constructionism" are often used interchangeably, there is an important difference in their mode of focus (Crotty 1998; Patton 2002).

In asserting a social constructionist stance, it is acknowledged that the understanding gained from this study is socially and contextually constructed through the interaction between staff and their environment and also through interaction between myself as a researcher and the study participants. Social constructionism places emphasis on the researcher and the research interaction itself as a major influence when it comes to creating knowledge. These elements will be explored further through a reflexive account of my own subjective view of the world and the interview interaction.

3.3. Research approach

In contrast to heavily philosophy-based approaches, pragmatism is described as a "toolkit" approach to research based on "practical realities" rather than epistemological positioning (Snape and Spencer 2003:14). There is a growing acceptance of

pragmatism as a mode of enquiry in its own right, underpinned by rising concerns that philosophical complexities may be undermining the researcher's ability to address practical considerations that form an integral part of the research process (Silverman 2006; Patton 2002; Snape and Spencer 2003; Bryman 2008). Patton (2002) argues that it is suitable to use qualitative methods because they are appropriate to a specific aim. Patton (2002) also describes various types of pragmatic approaches, divided into programme evaluation and quality assurance.

A pragmatic approach, for example, would be likely to consider questions for participants such as, "How do they perceive their lives? How do they make sense of what they experience?" Patton 2002:150). In the context of my study, by asking these sorts of practical questions, it is argued that pragmatic research can "illuminate" the lives and perspectives of participants holistically and in their own terms in a way that cannot always be achieved by heavily embedded philosophical approaches (Patton 2002:150–1).

The next section begins by outlining the methodological starting points of this research and how I arrived at a qualitative approach with some auto-ethnographic elements. It will also set out how I undertook the ethnography, documenting field notes while at work and conducting semi-structured interviews with staff, before detailing how I analysed and made sense of the abundance of data gathered using each of these techniques. Ethical considerations and research quality are also discussed. In keeping with a qualitative constructionist traditional approach, there is a reflexive account of my own subjective position in the research process.

3.4. Methodology

Methodology is a framework that guides choices of methods (Crotty 1988); it involves the way data are collected to address the research questions (Bhattacherjee 2012). There are numerous potential methodologies which govern the interpretivist framework, including ethnography, discourse analysis and grounded theory.

The choices we make, therefore, when using a research methodology, help to create a step in the research process between setting objectives and commencing field

work which leads to a discovery of the appropriate tool between the research topic and questions (Buchanan et al. 2007).

A qualitative approach was the methodology chosen, in a single case of an NHS Trust (the Trust is explored in more detail in Chapter 4). I decided to use a qualitative approach because the research question of how work stress affects mental health support workers involves exploration of the experiences (Van Manen 1990) of individuals. Qualitative research helps researchers to develop rich descriptions of meanings and behaviours and feelings evoked by workplace issues at one point in time and they can be used to understand mental maps of the elements in their world (Langley 1999).

In addition, as a mental health support worker myself, there was also a hint of auto-ethnography which enables contextually robust qualitative social research in which day-to-day interactions make up the essence of data produced (Mark 2008). By examining the social interactions of people within a specified environment, the researcher gains an understanding of how people experience the world.

Ethnography attempts to grasp “the natives’ point of view” (Malinowski 1922 in Schwartzman 1993:1) and to understand parts of the world as they are understood in the everyday lives of the people who actually live there (Cook and Crang 1995:4). While trying to understand the natives’ (here: mental health support workers) point of view, an ethnographic approach demands an appreciation of the way in which different individuals construct and make sense of the world (Hargreaves 2008). Hence, the almost total lack of pre-existing research on work-related stress among mental health support workers and the lack of attention to this selected group makes my research exploratory and therefore well suited to the use of ethnography.

In practical terms, ethnography entails an immersion in the field of study by the researcher, investigating everyday life and considering the participants’ perception of reality. It requires that the researcher be immersed in the settings being studied. My immersion in the setting as an insider and as a mental health support worker enabled researching with rather than on the participants. Having lived familiarity and shared cultural grounds, I was able to gain ready access to potential research participants and develop rapport (Giatzitzoglu et al. 2018). As a member of the organisation under

study, I was already absorbed “in the field”, helping me to better understand what the environment was, including the phenomenon under study.

Such immersion does however present difficulties in managing the impact of my own experiences. To mitigate, I sought to engage in reflexivity by keeping a diary (Van Manen 1990) that captured my observations and interpretations at work. This auto-ethnographic element capitalised on my personal experiences and enabled comparisons with my participants’ experiences as part of the analysis (Adams et al. 2015). My role as a researcher and my attempts at engaging in reflexivity will be discussed further in Section 3.7.

However, as with all other methodologies, there have been some criticisms regarding the use of ethnography in research. Miles and Huberman (2014) argue that ethnographic methods have a tendency to be descriptive, and during analysis, it can be difficult to condense the different sources of data. The aim is to arrive at a construction rather than a description of the phenomenon under investigation (Denscombe 2007). Additionally, organisational ethnography has been described as “jet plane ethnography” where researchers “rarely take a toothbrush” (Bate 1997:1150 in Hargreaves 2008:75).

3.5. Data collection

In order to maintain the study’s subjective and holistic focus, I used multiple collection methods to gather data: interviews, a reflective diary used as witnessing my experiences as a native, field notes as witnessing my observations as a researcher, and documents as data sources about the research context. In addition, case study research typically involves multiple data collection methods to explore a particular phenomenon (Starman 2013).

Although multiple methods of data collection are time consuming, one major advantage is that they can assist with the identification of common categories, themes and patterns across all datasets (Saunders et al. 2009). Multiple methods also provide depth and richness of data and highlight areas requiring further investigation. This is particularly important in/for inductive theorising, therefore making it possible to thoroughly address the research question.

In addition, multiple data sources provide better chances to answer the research question, which makes good qualitative research (Gioia et al. 2013). In this research, the methods all came within a “qualitative world view” (Saunders et al. 2009:152) but gave me an opportunity to evaluate the data with confidence and in more depth. Methods such as interaction with staff during my shifts, which formed part of my field diary, and analysis of some of the Trust’s internal documents such as the sickness absence policy and stress policy, provided me with complementary information.

The different methods together with the amount of data collected are provided in Table 3.1.

Table 3.1. Overview of Final Study Design

Method	Type	Quantity
Interviews **Workers (32)** **Managers (3)** Average time for each interview = 45–60 minutes. **Across 5 roles:** • Mental health support workers • Occupational health specialists • HR staff	Semi-structured	35

• Community mental health nurses Trade union representatives		
Field notes	In the form of field diary	Across 10 observation points Point 1 (2 pages) – 12/04/2019 Point 2 (3 pages) – 08/05/2019 Point 3 and 4 (5 pages in total) – 21/05/2019 Point 5-(2 pages)- 2/06/2019 Point 6 (2 pages)- 4/06/2019 Point 7 (3 pages)- 10/07/2019 Points 8 -9 (3 pages)- 4/08/2019 Point 10 (2 pages) 6/08/2019
Documentary	Policy guidance	Average pages for each policy = 21–30

		• Sickness absence policy • Stress at work policy • Rolling sickness absence policy • Staff stress survey

I will describe, explain and justify each method listed in the table above in the remainder of this section.

3.5.1. Qualitative interviews

Interviews were selected as the main source of data collection because they seek to minimise the influence of a researcher and help to gather facts about the values and behaviours of those interviewed (Reissner and Whittle 2021). The purpose of interviewing employees was to get a feel of what was going on and to better understand the nature of the problem (Saunders et al. 2003). Analysing the interview data helped me make sense of the problem under study.

Interviews have become one of the most common ways in which knowledge can be produced (Brinkman 2018). In interpretivist and social constructionist research such as this, there is no single “correct” or “objective” way of interpreting interview data (Reissner and Whittle 2021); rather there is an opportunity to “collect and rigorously examine narrative accounts of the social worlds” (Miller and Glassner 2011:145). Qualitative interviews attempt to “understand the world from the subjects’ points of view to unfold the meanings of their experiences and to uncover their lived world” (Brinkman and Kvale 2015:3). The qualitative approach determined the number of interviews to be conducted, especially with mental health support workers, who were the main source of information for the research project (Saunders and Townsend 2016).

Sampling and access to research participants

The interview process began when I started compiling the sample of potential participants. I sent an email request to the chief executive asking if a protocol could be added to the NHS Trust bulletin asking whether participants would consider taking part in my study. This was granted and a protocol sheet was developed stating the aim of the research and my full contact details. This was sent out to staff through the bulletin. Following this, I received numerous emails from participants requesting to be a part of the study.

If participants fitted my parameters, I provided them with more detail on the research topic as the first stage of obtaining “informed consent” (Brinkmann and Kvale 2015:93; Flick 2007:69). Most participants showed a lot of knowledge of my research topic and were eager to participate. Semi-structured interviews were used because they retain sufficient flexibility to explore responses from participants and initiate alternative discussion topics which may arise during the process of the interview (Alvesson 2011; Silverman 2014). In addition, they simultaneously allow the researcher to guide certain areas of interest around the topic of discussion to achieve the construction of knowledge, using a probing approach (Smith and Osborn 2008) to extract meaning from answers that are either superficial or unclear.

Purposive sampling creates a high level of correspondence between sampling and research questions because it involves choosing cases because they fulfil some criteria or have features in which we are interested (Silverman 2005; Bryman 2008). A snowballing sampling technique was used to recruit interviewees. Interviews with frontline managers and occupational health representatives were used to provide different views on similar issues. The researcher aimed to seek out settings and people within those settings where “the process being studied are most likely to occur” (Denzin and Lincoln 2000:370).

The initial strategy utilised in the current study can be conceptualised as criterion sampling (Patton 2002). The criterion for inclusion was participants’ current employment in an NHS Trust as a mental health support worker. Although I did not anticipate the need for an iterative approach to case inclusion, the realities of the field

resulted in a flexible sampling frame that developed over the course of the research. Therefore, my sampling frame did not only involve mental health support workers; an additional four roles emerged in the inclusion criteria. The reason for this was to get an overview across different staff groups.

Table 3.2. Study sample

Participant	Job role	Permanent/ temporary/ bank/agency	Pay band
P1	Mental health support worker	Permanent	Band 3
P2	Mental health support worker	Permanent	Band 3
P3	Mental health support worker	Permanent	Band 3
P4	Mental health support worker	Permanent	Band 3
P5	Mental health support worker	Permanent	Band 3
P6	HR	Permanent	Band 5
P7	HR	Permanent	Band 5
P8	Union	Permanent	Band 5
P9	Union	Permanent	Band 5
P10	Mental health support worker	Part time	Band 3

P11	Mental health support worker	Permanent	Band 3
P12	Mental health support worker	Permanent	Band 3
P13	Mental health support worker	Bank	Band 3
P14	Mental health support worker	Bank	Band 3
P15	Mental health support worker	Agency	Band 3
P16	Manager	Permanent	Band 7
P17	Mental health support worker	Permanent	Band 3
P18	Mental health support worker	Permanent	Band 3
P19	Mental health support worker	Permanent	Band 3
P20	Mental health support worker	Permanent	Band 3
P21	Mental health support worker	Permanent	Band 3
P22	Union	Permanent	Band 3
P23	Mental health support worker	Bank	Band 3

P24	Mental health support worker	Bank	Band 3
P25	Mental health support worker	Permanent	Band 3
P26	Mental health support worker	Bank	Band 3
P27	Mental health support worker	Permanent	Band 3
P28	Mental health support worker	Permanent	Band 3
P29	Mental health support worker	Permanent	Band 3
P30	Clinical Nurse	Permanent	Band 6
P31	Clinical Nurse	Permanent	Band 6
P32	Manager	Permanent	Band 7
P33	HR	Permanent	Band 5
P34	HR	Permanent	Band 5
P35	Manager	Permanent	Band 7

As described in the table above, the final study sample consisted of workers from NHS Pay Bands 3 to 6 (pay points which staff progress to annually). In nursing, pay bands are equated with seniority and authority. The bands range typically from 3 to 9. Band 3 is the lowest and mental health support workers fall into this group; the higher the band, the higher the person is in the organisational hierarchy.

The interview process and questions

The interview guide (see Appendix VIII) was developed based on key themes identified during the literature review process to help gather the material needed to investigate the broad area of interest (Brinkmann and Kvale 2015:129; Bryman and Bell 2015:486; Silverman 2013a:205). Some of the key themes explored included employee voice and recognition, role and position in organisation, organisational culture, workplace environment and personal factors.

The specific research question was used as a general guide to allow new and more interesting research questions (Alvesson 2011) to emerge during the data collation process. Two sets of interview questions were developed and used for the different groups of interviewees; one for mental health support workers and the other for occupational health specialists, HR and frontline managers (see Appendix VIII).

I ensured that most questions were open response questions; these are suitable when detailed information is needed (Ekinci 2015:4) and are likely to encourage co-construction of knowledge (Alvesson 2011; Roulston 2010). I spent time re-ordering the questions, for example putting personal questions such as age, job title, professional role and length of service at the beginning.

I therefore had to develop more conversational and free-flowing interview questions (exploratory in nature), bearing in mind that an interview in this research context is an interchange of views between two people having a conversation about a theme of mutual interest rather than a more formal interaction (Brinkmann and Kvale 2015). More conversational, free-flowing interview questions fitted in with the semi-structured approach, even though this could be interpreted as contradictory because it allowed me to ask additional questions when needed. The interview space became a reflexive space for participants during the interview.

All interviews were recorded so that I could concentrate on what was being said. I also took notes in case the audio recorder failed without us knowing (Czarniawska 2014). Most interviews took approximately one hour; the shortest was half an hour due to unforeseen circumstances. Rapport with participants was easily established by sharing any of my own experiences that supported theirs, although I tried to create a balance to ensure that I did not talk too much and that I followed the research

participants' interests and views rather than mine. This co-construction of empirical material ensured that I was constantly double checking to ensure that my interpretations reflected their intentions. For example, when some of the participants used words like "disciplinary", "measures" or even "uncertainty", I asked them to confirm what the term meant to them and how they understood it.

All interviews were fully transcribed by me as soon as possible after the interview had taken place. Transcribing myself was time consuming but it was a useful process which provided the first stage of immersion in the original data (Smith et al. 2009) while also allowing me to be familiar with the empirical material.

The interview location

It is important that the researcher finds a suitable place and time for interviews to be conducted; this must be a place where the interviewer and interviewee feel safe and comfortable (Roulston 2010). The date, time and location of each interview were arranged individually and chosen by participants when they "opted in" to the study, either by email or telephone depending on their preference. As many of the interviewees were recruited through the NHS Trust, I was familiar with, it was likely that I would know some of the interview locations.

Most participants chose their natural setting, which is their place of work, to be interviewed. Upon arrival at the participant's workplace, there was always time available for informal conversations while making tea or coffee which provided additional context. Most of the interviews took place in a private meeting room or an office; this allowed for fewer interruptions from colleagues. Only two participants requested an interview away from work and chose to be interviewed at their home.

At the end of the interview, I thanked participants for their time and asked if they had any questions or reflections on the interview. I noticed that informal conversations after the "official" interviews often provided a rich source of insight, and most were considered useful. In this case, I asked the participants if I could write the interaction down to be included in the study. Participants were often agreeable to this.

Upon leaving the interview situation, I made initial reflection notes on how the interview progressed, including major discussion points and anything else that had

surprised me or that linked to findings from previous interviews. This was done as soon as possible so that I didn't forget important information. My interview reflections noted an interesting dynamic for the interviews conducted in the workplace as opposed to those conducted at home. The two workers interviewed at home seemed to be less formal and created a more informal interaction.

After the interview, I emailed each participant to thank them for their time and participation unless they requested not to be contacted. A majority of the participants requested to see the interview transcript; these were sent out by post or email depending on their preferences.

In summary, criticism or support for the use of interviews appears to depend on what the researcher considers to be valid data and the extent to which interviews are intended to give access to "real" experience (Dingwall 1997; Rapley 2004; Silverman 2010). However, such criticisms were not a concern in my study as I was interested in staff's subjective interpretation of their working lives.

3.5.2. Field notes (diary entries)

An field diary formed part of my data collection and was brought into my thesis. I was able to make notes of discourse analysis and themes that cropped up. The ethnographic field notes resulted in a wealth of information from which findings and recommendations could be drawn.

Diary entries help researchers to record their immediate actions, conversations, reactions and thoughts and also to overcome the risk of memory recall. At the same time, they aid in gathering information that could support interviews, especially in situations where relevant information may have been missed or forgotten (Bryman 2012). They can also assist the researcher to obtain "rich sources of data which detail how people make sense of their everyday lives" (Silverman 2014:299).

As Wright Mills (2000) suggests, researchers should use their life experiences in their work in continually interpreting. I therefore decided to keep my own lived experience diary. Throughout the research process, I continued to work part time as a mental health support worker with the Trust, engaging in ethnography as part of my shift, and on the back of that were my reflections and field notes. These field notes

allowed me to formally record after my shifts, my reflections on what was happening among frontline staff. These notes were written up on a regular basis and consisted of the most interesting and noteworthy events and concerns that struck me at work. A number of these events were written as short notes at the time and then expanded as soon as possible after each shift. The lived experience diary was intended to act as an aide-memoire to highlight events of importance to my study, such as when people spoke about difficulties balancing home and life, and discussion around sickness triggers including stressors that people might be experiencing.

This selective diary entry approach agrees with Wright Mill's (2000:196) suggestion:

> Whenever you feel strongly about events or ideas you must try not to let them pass from your mind, but instead to formulate them for your files and in so doing draw out their implications, show yourself how either foolish these feelings or ideas are, or how they might be articulated into productive shape.

In completing the diary, I was also transcribing interviews, and this meant that I was actively implementing suggestions and findings that were emerging from the interviews. I was also reflecting upon these findings in relation to my own experience as a mental health support worker. This reflexive space provided me with support during times when I felt stressed, for example due to excessive workload.

I did not complete an entry every day I was on shift, but only when an event such as discussion around stressors in the workplace, episodes of violence and aggression, or sickness absence generated strong feelings either positive or negative. I recorded these events in my diary so that I was able to formulate them when needed, especially during analysis. However, during this process, emotions were experienced as is common in an ethnographic study (Mazzetti 2013).

3.5.3. Documents

Organisational documents play an important role in organisational life, providing details of policies and procedures and other records of events (Lee 2006); hence the need to add documents as one of my data collecting tools to address the research question. Different documents regarding work policies such as sickness absence and stress were collected from the Trust and analysed with permission granted by the Trust's

research and development department. I specifically requested the stress and sickness policies because they contained information that would be useful for the phenomenon under study. I was keen to know what the context of the guidance entailed, how the policies were implemented and what support was available for staff experiencing stress at work. In addition to this policy guidance, sickness absence rolling figures and current staff surveys on work-related stress were requested in advance of the interviews. These documents were also coded thematically, as with other analysis across the dataset.

3.6. Data analysis

Data analysis is the process of systematically breaking down things into their constituent parts and then relating them to each other in a precise and consistent manner. It is not a random dissection or method but rather a methodological examination (Braun and Clarke 2006; Nowells et al. 2017). This means that unlike other qualitative methodologies it is not tied to a particular theoretical or epistemological perspective (Braun and Clarke 2006). By so doing, connections and patterns are produced, and while guidelines exist as to how qualitative analysis can be undertaken, there are suggestions that each approach will be unique to the researcher depending on their skills, style and insights (Bryman 2012; Patton 2002; Silverman 2010).

In preparation for analysis, which was thematic in nature, each recorded interview was transcribed verbatim, including any audible emotion such as laughing. I transcribed all interviews myself and found it extremely valuable to be “immersed” in the data. Taking a thematic approach to data analysis seemed the most logical option in this study given its exploratory nature. Thematic analysis is described as an inductive technique driven by the data, involving identification of patterns, themes and categories and aiding in pattern recognition (Patton 2002). However, Braun and Clarke (2006) argue that thematic analysis can be used both inductively and deductively in terms of theorising. Thematic analysis was considered a useful balance between the “descriptive” works most commonly associated with ethnographic research and a more “explanatory” approach (Spencer et al. 2003:212).

Having coded the interview data, I then reviewed the additional data obtained from my lived experience diary entries. This material was analysed with a view to supporting, contradicting or enriching findings from the interview data. The lived experience diary was also used to highlight similarities and differences between my own experiences and those of the participants, but it also became a reflexive space for me.

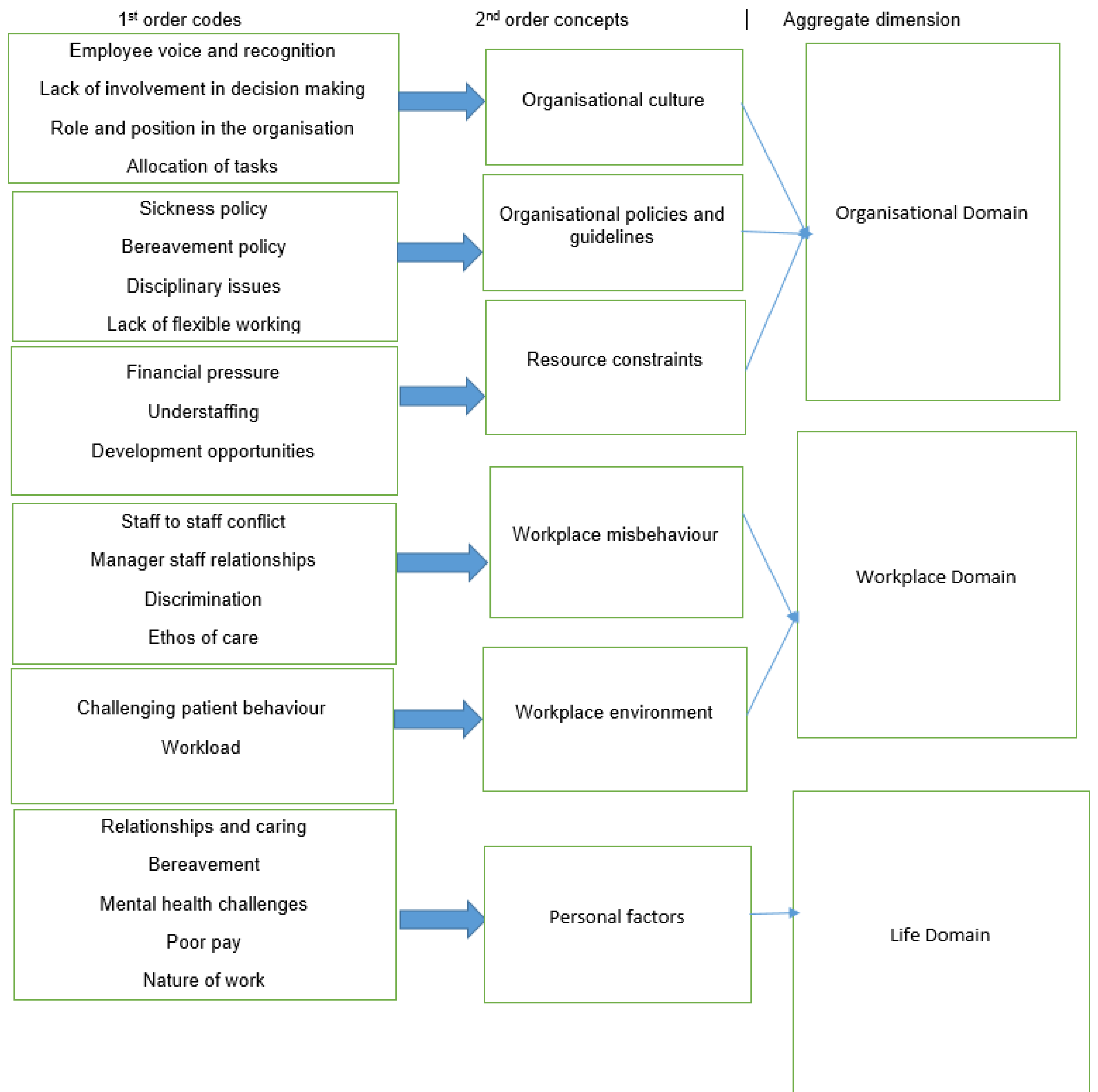
During the course of the transcription process, I familiarised myself with the data by reading and rereading the transcripts in order to gain a feel of the data “as a whole” (Ritchie and Spencer 1994:178). Alongside this, I also engaged with my reflections and field notes and wrote initial thoughts and key points on each transcript.

Process of analysis

During the process of analysis, I did some descriptive coding and then started to develop the data structure. The analysis proceeded in three stages. In the first step, all data (interview transcripts, field notes, documents) were coded thematically (Braun and Clarke 2006). I labelled passages of text that appeared to be important to understand mental health support workers’ lived experiences of stress, such as understaffing, allocation of work, lack of employee voice and recognition, manager-staff relationships and financial pressures.

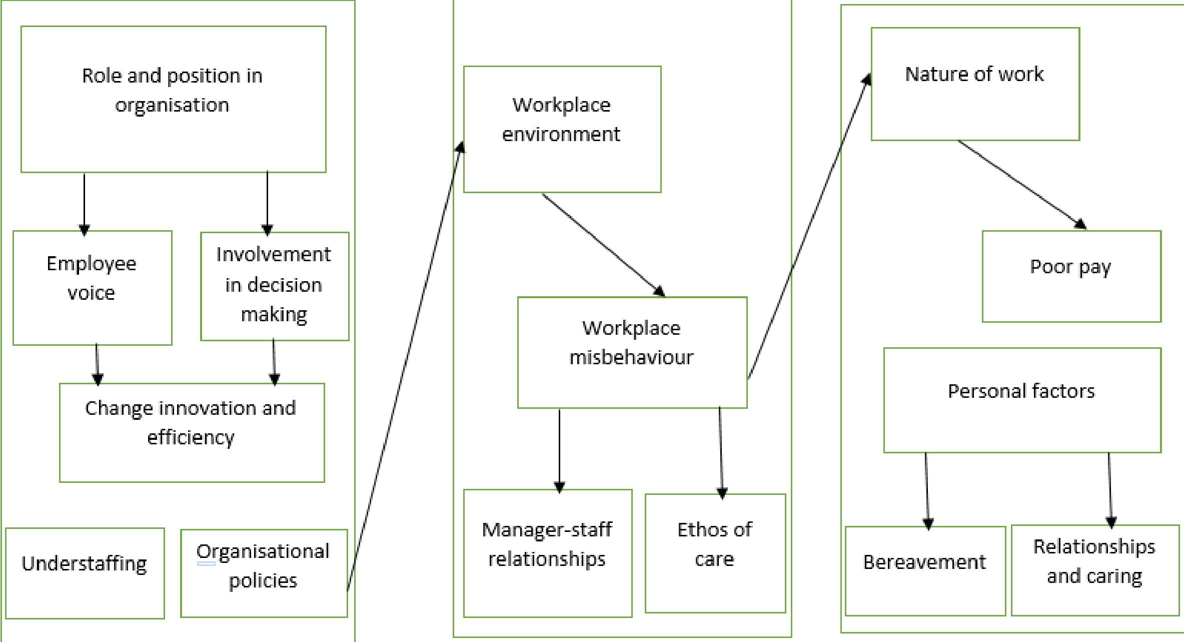
In the second step, these first-order codes then were categorised into second-order codes, using the causal connections between first-order codes inherent in the interviewees’ accounts, such as role and position in the organisation, change, innovation and efficiency, workplace environment and personal factors. This is represented in Figure 3.1 below.

Figure 3.1. 1st and 2nd order codes and aggregate dimension



In the third step, these second-order codes were then mapped onto three analytical domains (aggregate dimension) – organisational, workplace, personal/life – that informed the design and data collection procedure of this study. This involved interpreting the second-order themes identified in Step 2 using the causal connections between them. However, one of the limitations of the Gioia methodology was its linear nature which did not work well in this study. This is illustrated in Figure 3.2 below.

Figure 3.2. Theoretical model – Process framework



According to Langley (1999), data collected within organisational contexts have different characteristics such as dealing with sequences of events, and they often involve multiple domains as represented in Figure 3.2 above. The three analytical domains will be used to examine mental health support workers' lived experiences of stress in terms of organisation (Chapter 5), workplace (Chapter 6), and personal life (Chapter 7). The analytical model induced inductively through this process will be discussed in more detail in Chapter 8, bringing together the findings to theorise the interrelatedness of stressors at the organisational, workplace, and personal/life domains.

Following transcription and familiarisation, the next stage of data analysis was undertaken using the computer software package NVivo. NVivo was considered the most useful way to organise and manage the huge amounts of data that were generated, and it allowed easier movement than coding on paper. The initial thematic

framework was set up in NVivo as a series of tree nodes upon which all 35 transcripts were coded. NVivo identified participants' language and words to generate first-order (participant-based) concepts through constant comparison between different extracts. Through constant handling and rereading, I developed an intimate knowledge of the data (Pope et al. 2000). Subsequently, the first-order concepts were organised into a logical sequence, allowing the emergence of second-order themes after abstraction at a higher level. Finally, the flow of data was collapsed in aggregate dimensions, representing a series of second-order themes that had issues in common. The end point of data analysis was reached when all concepts had been classified and no more themes or aggregate dimensions emerged from the data.

3.7. Research quality and the role of the researcher (reflexivity)

The quality of a study can be assessed by how reliable and valid the conclusions are, but these can be hard to judge when it comes to qualitative research. According to Guba and Lincoln (1994), trustworthiness and authenticity are regarded as more appropriate criteria for assessing qualitative research. Trustworthiness can be achieved by "respondent validation" (Bryman 2012:391); I did this by checking with the participants that the common themes that emerged reflected what their intended meanings were.

I used a combination of qualitative methods, including my lived experience diary and documents. This facilitated in-depth analysis that generated insights and understanding of the working environment of mental health support workers. In addition, the use of computer software facilitated a flexible and more malleable approach, allowing for new nodes to be created and existing nodes renamed; these were merged together into different parent nodes.

Reflexivity has a key impact on research practice and there is a consensus that it is reflective and recursive process (Reissner 2018). Ethnographers can face difficulties in researching in their own employing organisation. They also have to deal with the emotional challenge of living in two worlds: their own and that of the research participants (Mazzetti 2018). Therefore, it is important for ethnographers to produce a reflexive account of their experiences and their field work. In addition, reflexivity is

particularly important to social constructionists and ethnographers because the relationship between the researcher and researched is central to the co-creation of knowledge (Giatzitzoglu 2018; Crotty 1998).

According to Boud et al. (1985), reflection is an important human activity which helps people recapture their experience, mull it over, think about it and evaluate it. Reflexivity is also described as a way of bringing cultural and political consciousness, self-awareness and ownership of one's perspective into research – a process involving "self-questioning and self-understanding" (Patton 2002). Researching the complex and dynamic nature of work-related stress can pose a number of challenges for the researcher (Mazzetti 2018), so it was particularly important for me to be able to create a reflexive space through the research process to deal with the complexities of discussing such a sensitive topic. Whilst undertaking this research, it became apparent that not only did I need to think much more deeply about the assumptions, results and claims (Alvesson 2011) made if the data generated were to provide a true representation of mental health support workers; I needed to also be more self-critical. As a mental health support worker myself, it is inevitable that my interpretation will reflect my personal experiences, but it is important to be able to appreciate the similarities and differences between the people we are studying and ourselves (Silverman 2013b:13). With this in mind, I focused on the participants' accounts to allow themes to emerge from them. I then identified similarities and differences between the participants' accounts and ensured they were fully supported by direct quotations from their interview responses. I have also provided details of my approaches to analysis to achieve transparency, allowing the reader to understand how the data were constructed and interpreted.

I also used reflexive tools such as my lived experience diary to supplement and address the limitations of the interview data. This helped me to openly position myself within the social world which I was studying to ascertain the trustworthiness and authenticity of the research findings (Guba and Lincoln 1994).

3.8. Research Ethics

Most professions have well-defined codes of ethics set in place, including guidelines ranging from maintaining confidentiality to securing permission and access (Miles and Huberman 2014). Every researcher, regardless of the discipline they belong to, must bear in mind the different ethical considerations at each stage of the research process from initial design to data collection through to findings. The flexible and socially embedded nature of qualitative inquiry brings its own uniqueness and set of considerations by setting a research environment which is difficult to predict (Bryman 2008). Additionally, the depth of a qualitative study often requires intimate engagement with both the public and private lives of individuals (Mason 1996:166–7). This intimate nature emphasises the importance of ethical codes of conduct to qualitative researchers (Lewis 2005).

At the onset of a study requiring interviews, there are many ethical questions to be considered. These include “What are the benefits of the study?” (Brinkmann and Kvale 2015) or “How will the study contribute towards the improvement of the situation investigated?” (Kvale 1996). The intended contribution of this study was to increase knowledge of what causes stress for mental health support workers and how this can be managed by the NHS as an organisation. Increased understanding of this phenomenon can also be used to underpin policy-making decisions (Mandi and Biletta 2018). A further contribution is to create awareness of this often unheard and under-researched group of staff.

The research information sheet and consent form were approved by Newcastle University’s Faculty of Humanities and Social Sciences Ethics Committee on 19 June 2018. These were then provided to the Trust as part of their requirements for research approval. Once approval was granted, the Trust gave the green light to begin recruitment of participants on 25 February 2019. Prior to commencing interviews, full details of the research were provided, alongside an informed consent sheet (see Appendix IV), to ensure that participant’s full informed consent was given. I also issued an information sheet (see Appendix III) together with a debriefing sheet/email template (see Appendix I and II) stating what the purpose of the research was and providing participants with details of occupational health specialists to provide emotional support

after the interview, if needed. I also provided them with information about the transcripts of interviews and thanked them for their time.

Consent from participants only and not from the organisation was obtained as it was their experience that was of interest. Interviews took place in participants' own time rather than the time of the organisation. Each participant was provided with an information sheet outlining the purpose of the research, what was required of them regarding the study and full contact details if they had any questions prior to the interview. A consent form was also provided at the interview for signature (see Appendix).

According to the Economic and Social Research Council (ESRC) Framework, research needs to be carried out to the highest standards of ethical practice, and researchers are accountable and responsible for maintaining these standards throughout the process of their research (UKRI 2021). As such, key ethical considerations associated with qualitative research are grouped into four main areas:

1. Informed consent
2. Anonymity and confidentiality
3. Protecting participants from harm
4. Protecting the researcher from harm

Informed Consent

Informed consent refers to the provision of relevant information to potential participants about whether or not they would be willing to take part in the research. Therefore, it is a significant process in ensuring that participation is voluntary and fully understood (Silverman 2010).

Full informed consent involves explanations of the following:

1. Potential risks or discomfort
2 Who will have access to the data collected
3 How anonymity and confidentiality will be preserved
4 The overall purpose of the research, including who is undertaking it and the kind of information needed

5 The role of the participants in the study and the amount of time required (Adapted from Diener and Crandall 1978 and Gray 2004).

Each of the points listed above was addressed in the Participant Information Sheet and was presented to participants, who opted in before any interviews commenced. Also, at the start of each interview, I described the study verbally, including the overall aim of the research, my background and my reasons for carrying out the research. Further to this, participants were asked to confirm if they had read and understood the information sheet and were also given the opportunity to ask any questions. The information sheet detailed the aims and purpose of my research as well as what the research entailed, so that participants were able to make informed decisions over whether they could participate in the research or not. In the sheet, they were also informed that participation was voluntary and that they could withdraw from the research without any penalty. I also made clear how the collected data would be used and stored.

All participants were then given a consent form detailing the type of research and ethical provisions surrounding the research to ensure informed consent. They were then asked to sign the form to confirm their understanding and agreement. The consent form and information sheet can be found in (Appendix (IV). The consent form complemented the information sheet and the debriefing sheet. The debriefing sheet was a two-stage sheet used to thank participants for their participation, time and openness in the research.

At the end of each interview, participants were asked if they had any further questions following their participation, and I offered them the opportunity to fill in a contact details form should they wish to be sent a summary of the research findings. I also handed them a copy of my contact details.

Anonymity and Confidentiality

Anonymity and confidentiality are two separate concepts that can be used interchangeably by researchers. Anonymity means that the identity of participants is not known or disclosed outside the research team, while confidentiality means that the data collected are not attributed to an identified participant (Lewis 2005). To ensure

good practice, the researcher is required to ensure that every attempt is made to uphold the anonymity and confidentiality of participants (Bryman 2008).

Sometimes, anonymity can be difficult to uphold in research settings where participation is arranged by a third party (Lewis 2005). This was the main risk in my study because sometimes, in gaining access to participants, information was sent via a "gatekeeper", in most cases their line managers. However, attempts were made to uphold anonymity as far as possible, and any personal information and data collected remained anonymised. In almost all the cases, once information had been passed on to participants, no further contact was made with the gatekeepers other than to request a reminder email to be sent to staff or to arrange for a manager interview.

In adhering to confidentiality and anonymity and as part of the ethical process regarding the use of ethnographic field notes, I clarified with the University Ethics Committees and the Trust Research and Development department through an ethics review form (See Appendix V) that I would not be using participant observation for this research. This was because participant observation is typically associated with specific meetings and events, whereas I intended to do an ethnographic immersion consisting of a diary to note observations and reflections at work. Further, my observations did not involve clinical staff or their interactions with patients or relatives. Rather, ethnographic field notes allowed me to formally record, during my shift, my reflections on what was happening among frontline staff. Although these field notes involved covert observations, they were disclosed to participants should they require it.

At the end of the field work, contact details were only stored for those who chose to receive a summary of the research findings. In accordance with the Data Protection Act (1998), I ensured that personal data were not kept longer than necessary and were stored securely. There were no names in the transcripts and field notes; rather, participants were identified by numbers. In addition, the audio recorder and transcripts were stored separately in locked filing cabinets. No quotations or potentially identifiable information featured in the summary of findings that was sent to participants.

3.9. Limitations

A successful analysis is interpretative, transparent and plausible (Reid et al. 2005:20). To achieve this, there are different aspects that need to be addressed. One of the challenges relating to data gathered through semi-structured interviews is that participants are likely to be more "self-conscious and reflective" than in other circumstances and data collation and analysis is heavily reliant on the researcher's views and interpretations (Watson and Watson 2012:701). Also, there is a lack of transparency when selecting participants and it is impossible to generalise from the results (Bryman and Bell 2015). To mitigate these problems, there is a need for sufficient reflexivity and support from other methods (Denscombe 2007; Bryman and Bell 2015).

While empirical generalisation from qualitative, ethnographic and interview-based research is challenging, theoretical insights can be transferred to similar contexts and situations (Smith et al. 2009). Despite these drawbacks, I am confident that interviews were the most appropriate method of obtaining data on the experiences of mental health support workers, because there were a wide range of issues that would not have been open and responsive to observation, making interviews the only viable means of finding out about them (Bryman 2012).

3.10. Concluding Remark

This chapter has outlined the broad theoretical underpinnings and subsequent decisions that led to the choice of methodology and methods: a qualitative interview-based study supplemented by a field diary and document analysis. This study was situated within an interpretivist paradigm informed by social constructionism. In keeping with the social constructionist approach, the study highlighted a consideration of my own subjective position, including my feelings and thoughts within the research process. The remainder of this chapter discussed issues related to key ethical considerations, including consent, confidentiality and anonymity, and the quality of research, which further underpins the study's overall design. The next chapter will set the scene and introduce the research context in which the study is situated.

Chapter 4. Research context: the organisation of mental healthcare in England

4.1. Introduction

In this chapter, the National Health Service (NHS) is briefly introduced as an organisation, and an explanation is offered of how mental healthcare is provided by the NHS in collaboration with partner agencies. This is followed by an overview of mental healthcare in the UK, including the present economic and societal concerns. Focus is placed on mental health, inpatient care and care in the community. The NHS Trust serving as the case study in this research is then introduced, through its vision, mission and place in the wider NHS structure, including the areas where it has autonomy and the areas overseen by the NHS. In addition, details are outlined of the Trust's policies and procedures to safeguard the mental health of its staff. Finally, this chapter will explore how funding is distributed in mental health services, including its impact on provision of care and the relationship between funding, services and the workforce. The realities of staffing mental health services and the impact on quality and safety of care are also briefly discussed.

Health policies that have shaped and improved the mental health systems in the UK include *The National Service Framework for Mental Health: Modern Standards and Service Models* (DoH 1999), and *No Health without Mental Health: A Cross Government Mental Health Strategy for People of All Ages* (DoH 2011a). These policies have emphasised the need for clear care planning, involving patients and carers wherever possible. There has also been an agenda of implementing and transforming mental healthcare in the UK; hence the implementation of *The Five Year Forward View for Mental Health*, a report from the independent Mental Health Task Force to the NHS in England (NHS England 2016). This report was proposed due to the costs of mental healthcare to individuals, their families, the NHS and wider society. The implementation plan set out in the document is for the benefit of the whole NHS and not just for mental health services, and it is a financial necessity to manage the challenges of the years ahead (King's Fund 2017). According to the National Mental Health Director, Claire Murdoch:

> People can, and do, recover from mental ill health. The evidence is clear that improving outcomes for people with mental health problems supports them to achieve

greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality. (Implementing the Five Year Forward View for Mental Health, February 2016)

Implementing the *Five Year Forward View* is anticipated to increase access to mental healthcare and to improve services. However, delivering this agenda requires significant expansion of the current workforce (King's Fund 2017). This means that by 2020/21, an additional 1,700 supervisors and therapists are required to meet the increasing demand on health services, in addition to improving the retention of already existing staff based on recommended caseloads (Kings Fund 2017). However, given that this programme was supposed to end in 2021, it is unclear if there has been a delay to its completion as a result of the Covid-19 pandemic.

4.2. The NHS as the UK's main public healthcare provider

The NHS, short for National Health Service, was the first universal healthcare system in the world; it was created after the Second World War and was founded "in place of fear" (Light 2003). With more than 1.4 million staff, the NHS is the largest employer in the UK and is expected to lead by example in looking after the health and wellbeing of its staff. To support this statement, the Department of Health commissioned Dr Steve's Boorman's report on *The Health and Wellbeing of NHS Staff.* As a result, there is now a pledge in the NHS constitution to provide support and opportunities for staff to maintain their health, wellbeing and safety. Across the wider NHS, staff endeavour to deliver efficient services to a growing population of people living with mental health challenges in a context of severely constrained resources (Collins 2020).

The NHS is a public service that is habitually valued by the British people and ranked highly in international comparisons (Light 2003). It was created in 1948 and its founding principle is to provide access to care for everyone on the basis of need and want, not ability to pay; this remains very important today. There has been a considerable improvement in health outcomes among the UK population since the NHS was formed; for example, life expectancy has increased by 12 years from 68 to 80 (Majeed et al. 2018). The NHS was designed to provide essentially free care, at the point of need, irrespective of age, health, race, religion, social status or the ability

to pay. While there are smaller private care and nursing homes, the NHS remains the single largest employer of carers and nurses in the health sector.

According to the Ross and Naylor (2017), the NHS structure comprises of NHS England; NHS Improvement, which is responsible for providing direction on service transformation and improvement nationally; and the Care Quality Commission (CQC), whose role is to not only monitor and register care providers but to rate and inspect NHS services in order to protect patients. In addition, the NHS Trusts and Foundation Trusts have different sub-organisations like community services, mental health services, hospital services and ambulance services (King's Fund 2017). When it comes to focusing on patient experience and recovery, and intervening to improve the quality of services provided, delivering care can become overwhelming both for the staff involved and the organisation itself. However, the need to do this within a system that is complex and within an organisation that is under pressure to increase efficiency is a fundamental challenge which needs a solution (Goodrich and Cornwell 2008).

Within the organisation, the ideal is that mental health support workers, like other healthcare workers, are highly motivated to care for their patients with humanity and decency, as stipulated by the Department of Health (2007). However, sometimes these behaviours cannot be realistically enacted in practice, with stress playing a role. From my experience as a support worker, healthcare staff can become overwhelmed in terms of the number of hours they work and also from psychological effects.

The NHS is constantly changing due to advances in research evidence, which lead to new practices, and technology transformation in the workplace (Lumbers 2018). Evidence of the dynamics and challenges of change in the face of increasingly complex healthcare needs such as disability or sensory impairments, and the pressure on the NHS, indicate that change will always be a central issue. This view is based on reports from interviews and on literature, as will be discussed in the next section.

The *Five-Year Forward View*, which is NHS England's 2014 strategy, sets out a vision for a healthcare system with a plan that requires a significant change in practice, thinking and the delivery of healthcare over the next decade (King's Fund 2017). This means making sure people get access to the right help at the right time

and ensuring that decisive steps are taken to break down barriers in the way services are provided to reshape how care is delivered.

The NHS is not a single organisation; rather it consists of multiple organisations. This means that the NHS does not have a central working recruitment team. As provided on its website, the NHS is constantly changing in structure, responsibilities and specialities. In 2019, NHS England and NHS Improvement merged in order to better support the NHS and to improve care given to patients (NHS England 2020). This has initiated a new long-term plan for the NHS, which will bring some changes to the health service and some significant improvements to care quality and outcomes (NHS Improvement 2020).

Ross and Naylor (2017) shows that NHS England and NHS Improvement are responsible for providing national direction for service improvement, transformation, governance and accountability. The Care Quality Commission is responsible for registering care providers and monitoring, inspecting and rating their services to protect users, while the regional NHS England and NHS Improvement teams ensure the quality, financial and operational performance of the regional NHS organisations. Finally, the Sustainability Transformational Partnerships bring together NHS providers and commissioners, local authorities and other local groups to engage and collaborate, planning long-term needs for local communities. This is similar to the Integrated Care Partnerships and Primary Care Networks responsible for providing collaborative service delivery, such as, in the case of ICP, providing services for hospitals, communities, mental health services and GPs; and the PCN, responsible for providing collaborative care services to local communities, social care and the voluntary sector (Ross and Naylor 2017).

The NHS mental health provider studied in this research has a specific hierarchical structure which includes a chair, chief executive, finance director/deputy executive director, executive medical director, acting executive director of workforce, executive director of commissioning and quality assurance, executive director of nursing and chief operating officer, and seven non-executive directors. This board team has diverse responsibilities and decision-making duties. The overall goal of the team is to ensure that quality care and effective service delivery continues to be on offer for service users. This structure represents the governing power of the trust,

which must ensure that as new challenges emerge, high quality and sustainable services continue to be delivered.

4.3. Mental healthcare in the UK

4.3.1. Mental health awareness

Mental health can be defined as the mental and emotional state in which people feel capable to handle the common stresses of life (WHO 2009). According to the World Health Organisation's (WHO) definition, it is a state of wellbeing whereby a person realises his/her own abilities, is able to cope with the normal stresses of everyday life, can work productively and is able to make a contribution to his or her community (WHO 2009). However, a person's mental health can be influenced by social, economic, political, emotional and psychological factors.

The Centre for Mental Health estimates that the cost of mental health at work in the UK is around £30 billion annually (Baker 2020). In addition, the NHS in England estimated that a total of £13 billion would be spent on mental health services between 2019 and 2020. In the UK, one in four people is suggested to experience mental health problems at some point in their lives, described as the "largest single cause of disability representing well over 23% of the nation's total health burden" (Department of Health 2011a). Statistics show that around one in six adults have experienced a common mental health problem like depression or anxiety (Baker 2020) and women employed full time are twice as likely to have a common mental health problem as men who are employed in full-time positions (Stansfield et al. 1997).

Mental health and wellbeing are fundamental to our individual abilities as persons and also collectively as a society so that we are able to think, emote, earn a living, interact with one another and enjoy life. Hence, the promotion, restoration and protection of mental health services can be seen as a significant concern for individuals, communities and societies across the globe (WHO 2013). Mental health problems have become a growing public health concern, not just in the UK but around the world, and are said to be one of the main causes of disease burden (Vos et al. 2013). The *Five Year Forward View*, a report implemented by NHS England in 2016, emphasises the need to make physical and mental healthcare equally important. It recommends that by 2020/21, at least 280,000 people living with severe mental health

problems should have their physical health needs met and should be offered screening and secondary prevention reflecting their higher risk of poor physical health (Vos et al. 2015).

Not only are mental health problems now a common concern for healthcare providers both as a workplace issue and a barrier for help seeking (Knaak et al. 2017), but there are also a lot of societal concerns. Nine out of 10 people who experience mental health challenges say that they face stigma and discrimination, thus causing barriers to accessing quality care (Knaak et al. 2017). The extant research has shown that a large proportion of the general population with mental health issues does not seek professional help (Iversen et al. 2011).

Gradually, mental health is receiving a higher profile in society, and recently a new light has been shone on mental health services, which, according to the King's Fund (2017), were previously described as a "Cinderella service". After years of fighting the stigma of poor mental health, the tide seems to be turning. Celebrities from fields as diverse as music, TV and sport have spoken out about their struggles with mental health, and members of the royal family have also lent their support. In 2018, the world's first ever Suicide Prevention Minister (Jackie Doyle-Price) was appointed.

In summary, this section has discussed mental healthcare in the UK and the societal concerns about mental health. Mental health is increasingly receiving a higher profile in society and the stigma around mental illness is now being challenged. There are multiple attempts to challenge this stigma and get more people the help that they need through campaigns and seeking treatment. However, the reduction of the stigma around mental health means that more people are seeking professional help.

4.3.2. Provision of mental healthcare in the UK

Mental healthcare in the UK is provided by private and third-party organisations, but most of the care is in the hands of the NHS, with Mental Health Trusts providing more than 80% of mental healthcare (Gilburt 2018). Attention has turned from improving value in physical health services to focusing on achieving value in services for people with mental health issues in England (Collins 2019).

By the end of December 2020, in England, 1,392,002 people were in contact with mental health services and 966,998 of these were in contact with adult mental

health services (NHS Digital 2022). Also, 20,206 people were subject to the Mental Health Act, including 14,232 people detained in hospital (NHS Digital 2022). This means that every year, a large proportion of people with severe mental health challenges enter "locked rehabilitation" wards, often for a long period of time and far from home (NHS Digital 2018; Wright 2017). People who require hospital admission for mental health issues may be treated in a mental health unit of an acute general hospital, or in a mental health unit that often provides a variety of mental health treatment. This may include Child and Adolescent Mental Health Services (CAMHS), psychiatric intensive care and secure units (Brooker and Waugh 2013). This leads to some mental health services being accused of "containment" rather than helping individuals live fulfilling and independent lives. Mental health services sometimes also provide community teams to help patients recover from a mental health crisis and prevent reoccurring hospital admissions; alongside these, specialist services are provided to support people with drug and alcohol misuse problems (Brooker and Waugh 2013).

Mental healthcare in the NHS is usually provided through inpatient care services and community care, including rehabilitation. In the community, mental healthcare is provided by treating people in their homes or from clinics closer to home. Community services play a vital role in keeping people well, treating and managing long-term conditions and supporting people to live independently in their homes while proving the treatment that they need (Rolewicz and Palmer (2019). The exact range of services provided varies according to local areas, but includes adult community nursing and specialist long-term conditions in mental health, covering a wide range of activities aimed at promoting recovery (Rolewicz and Palmer (2019).

Despite significant developments in community care, at the start of the century a call for reform had started due to concerns around staff retention, overburdening caseloads and burnout for mental health specialists, which were fast becoming an employment crisis and a concern (Griffiths et al. 2001). At about the same time, the National Service Framework for Mental Health (DoH 1999) and the NHS Plan (DoH 2000) in consultation with the Royal College of Psychiatrists set out an agenda for the modernisation and development of mental healthcare. In particular, the NHS Plan (DoH 2000) set out plans for the extensive transformation of community services over

a 10-year period, recommending the development of a number of new community teams, including staff roles (Harrison 2011).

Over the last 20 years, community care in mental health settings has come to cover the provision of specialist services, day care and residential services to mental health service users (Harrison 2011). This has made a significant difference because professionals are now able to manage and distribute caseloads to the appropriate services. Each year, community health services account for around £10 billion of the NHS budget and one-fifth of the total NHS workforce (Rolewicz and Palmer (2019). It is envisaged that by 2020/21, community-based mental health services for adults will be enhanced in that there will be increased support to balance access to timely evidence-based interventions and integrate appropriately to primary care, social care and other local services, to ensure the efficient delivery of the adult mental health system (Kings Fund 2017). By doing this, services can begin to slowly close the treatment gap, thus helping to improve outcomes and reducing hospital admissions for people with more severe mental health needs.

For inpatient mental health services, provision of care is usually on admission wards. These are regarded as high-risk environments because ward areas can be hostile and violent. This is reflected in the NHS benchmarking network data which suggests that there are high incidences of violence and aggression towards staff and other patients. However, inpatient mental health wards are known to provide a safe and therapeutic environment for people suffering from mental health problems as intensive treatment is provided and recovery is promoted from the very moment of admission. Wards are staffed by nurses, nursing assistants, psychiatrists, therapists, pharmacists and activity coordinators.

The Independent Commission on Acute Psychiatric Care highlighted that the acute mental health system is under significant pressure, with difficulty in accessing care that is aggravated by poor quality of care, low morale and inadequate staffing in most instances (Gilburt 2018). According to NHS England, the majority of acute mental health services are inadequately resourced, with caseloads above levels that allow staff groups to perform their duties of a community-based crisis response. In some cases, intensive home treatment is an alternative to admission into hospital.

It is therefore necessary to deliver the expansion of acute mental health services, not only to ease the sufferings of patients in crisis but also to reduce the pressure on acute-inpatient mental healthcare. However, expanding mental health services will require a highly skilled confident workforce with the right capacity and skill mix to be able to deliver evidence-based care. Especially for perinatal mental healthcare, multidisciplinary teams are an essential part of that service. They must be able to deliver therapeutic and psychological interventions and effective nursing capacity, as well as building sustainable relationships with allied health professionals such as occupational therapists, nursery nurses and social care. Other key groups such as obstetrics, health visiting teams and the wider mental health service are also vital for referrals and providing advice and guidance.

4.3.3. Funding for Mental Healthcare

When it comes to funding, one of the key highlights is that the NHS remains in the centre of one of the longest funding squeezes in its history, with a £4 billion gap in 2018/19 (McKenna 2018). Beech at al. (2018) states that the NHS has been managing through a severe period of funding shortages since 2010 and there is not enough budget available for the NHS to do everything, causing pressure. There are trade-offs and tough decisions are inevitable.

Mental healthcare has received comparatively little funding and the impact of this on NHS mental health services is evident in a number of ways. For example, it has become clear that NHS mental health providers are focusing on transforming care and restructuring services in a bid to reduce costs. They are prioritising approaches that support recovery and management; this has helped many mental healthcare providers to keep from falling into deficit (Gilburt 2018).

Also, the lack of adequately trained staff is particularly noticeable in mental healthcare, and this has been identified as not only an area of intensive growth which is demanding but also a key challenge to policymakers worldwide (WHO 2009). At the time of writing, it appears to be a turbulent time for the NHS in terms of resource constraints, especially in terms of understaffing exacerbated by Brexit and the current COVID-19 pandemic. Hence, some scholars believe that increasing role flexibility has the potential to address workforce shortages in the healthcare sector and enhance

accessibility of health services to meet continuously increasing demand (King et al. 2018). However, while the introduction of role flexibility is seen as a key factor to optimise the healthcare workforce, some professions perceive that this approach may jeopardise role boundaries (King et al. 2018).

The pace of change has also led to a reduction in access to these services (Gilburt 2018). Furthermore, the economic and societal costs of mental health issues cannot be underestimated and while there is increased attention to the promotion of positive mental health, which has grown over the last couple of years, there is still a major inequality in how funds are distributed. For example, the reduction in funds allocated to mental health in 2014/15 exceeded the reductions for hospitals providing physical care (King's Fund 2015). This led many to conclude that there might be an institutional bias against mental health services (King's Fund 2015). Also, there is a clear lack of skilled workers compared to other areas of healthcare (WHO 2005; 2009).

Given the role of mental health trusts in ensuring appropriate mental healthcare, their income is substantial, and it is an important marker of their ability to provide the care outlined in the *Five-Year Forward View* for Mental Health. Although there was a growth in income for mental health trusts in 2016/17, many NHS Trusts continue to see a decline in their income despite the implementation of the Mental Health Investment Standard. This is because funding for mental health does not always make its way to the frontline services that need it most (NHS Provider 2019). This invariably places constraints on staffing in mental health services (Gilburt 2018). These constraints are manifested through staff shortages due to sickness absence, excessive workload, poor wellbeing and reduced ability for staff to provide good-quality care (British Medical Association 2021).

While NHS England has attempted to improve spending on mental health through the implementation of the Mental Health Investment Standard, concerns have been raised by Clinical Commissioning Groups (CCGs) about meeting such expectations due to their current stagnated resource levels (King's Fund 2018). Like other spending in the health sector, the greatest proportion of funding for mental healthcare is allocated to NHS England; the plan was to spend £12.2 billion in 2018/2019 (Gilburt 2018). Amidst estimates that the cost of treating mental health problems could double in the next 20 years, (DoH 2009; 2011), the future of mental healthcare calls for both professional and public concern (Hill 2011). This means that

the provision of mental health services should be prioritised. Additionally, while there is emphasis on the allocation of funding to improve performance and support financial sustainability within acute services such as accident and emergency departments and inpatient and outpatient medicine and surgery, the gap that exists in funding between mental health services and acute services will continue.

The priority allocated by national leaders to expanding the mental health workforce is not yet adequately matched by the priority to ensure there is a steady rise in income among NHS mental healthcare providers and acute hospital providers to support this (Charles and Felton, 2019). Although there is emphasis on allocating funding to support financial sustainability and improve performance, the gap between growth in funding for NHS mental health providers and that for NHS acute providers still remains (Gilburt 2018).

In summary, this section has given an overview of mental healthcare in the UK and also discussed the NHS as an organisation and the roles and duties of mental health support workers. Societal concerns about mental health were also discussed. Although a new light has recently been shone on mental health services, there are still barriers to self-seeking help because of the stigma associated with it. Finally, this section has explored how funding is being distributed in mental health services and its impact on the delivery of care.

The next section will focus on the provision of mental healthcare across the NHS including its workforce, and the place of the Trust – the research setting in the NHS structure.

4.3.4. The workforce in mental healthcare

The provision of care and treatment for patients with mental health issues is heavily reliant on a good workforce: one that is aimed at improving productivity and staff morale and reducing costs due to absenteeism and staff turnover. This is because in mental health services, staffing overwhelmingly constitutes the main resource (Gilburt, 2018). Providing high-quality care to patients usually requires two things: firstly, that NHS Trusts are able to recruit and retain the right mix of staff, and secondly, that these staff actually exist and are keen to work for the NHS (Gilburt 2018). Unfortunately, there are fundamental issues with the supply and availability of key staffing groups in

mental health trusts, and it is notable that the use of temporary staffing is one of the most significant pressures affecting their financial position (Gilburt 2018).

A recent survey of staff working in mental health services revealed that out of 1,071 respondents, 74% reported feeling stressed at least weekly due to the nature of their job; 36% felt stressed every day and 22% had taken time off as a result of work-related stress in the past year (Baker 2020; Gilburt 2018). Respondents also reported staff shortages as a major factor preventing people from accessing services early (74%) and a reason for the increased incidence of violence and aggression experienced in the past year (87%).

Although there is a temptation to reshape the current workforce, caution is advised because the expansion of mental health services will require capacity and building skills within the workforce (NHS Digital 2017). This means there will be additional training for current staff in new core competencies such as resilience, targeted at long-term conditions and medically unexplained symptoms that may arise. There will also be training for new staff to increase overall capacity, such as the 3,000 additional mental health therapists located in primary care settings (NHS Digital 2017).

The table below shows the indicative trajectory of additional staff that will be needed to deliver this objective year after year.

Table 4.1: Workforce statistics According to NHS Digital (2017–2021)

Workforce	2016/17	2017/18	2018/19	2019/20	2020/21
Psychological wellbeing practitioners	210	350	338	338	338
High intensity therapists	390	650	630	630	630
Mental health nurses	25,408	38,175	37,297		43,186

In summary, this section has explored the provision of mental healthcare in the NHS and its current workforce; care is provided via inpatient services, community care and rehabilitation services. The range of services provided is dependent on local areas and acute mental health services are under significant pressure due to inadequate staffing and difficulty in accessing care. Although the provision of care is heavily reliant on a good workforce, staff shortage remains a major problem preventing people from accessing mental health services early. Currently, there are no reliable figures about the number of mental health workers.

The sociology of professions

Many clinical healthcare support workers assist healthcare professionals in the delivery of patient care. They work with an individual practitioner or a team in roles that include preparing and explaining treatment procedures to patients and updating their records. You can enter most of these roles with GCSEs. However, most do not need any particular qualifications. The essential requirements are a caring nature and an ability to follow instructions and procedures carefully.

4.3.4. The role and duties of mental health support workers within the NHS

The number of support workers has grown rapidly. According to Nuffield Trust analysis, recent numbers in this group of workers have risen from 280,000 in 2009 to over 370,000 in 2021 (Rolewicz and Palmer 2021). Currently, support workers are non-registered healthcare staff and are not subject to the professional regulation of registered healthcare professionals (Henshall et al. 2018).

Support workers are used in a wide variety of fields in the NHS. As part of their role they are expected to support patients in their activities of daily living, monitoring patients' physical health, performing therapeutic roles and engaging in social participation (see Table 4.2 below).

Table 4.2 Summary of support workers' role provided by Wilberforce et al. (2017)

Role	Key Features
Physical Health	Collecting urine samples; taking physical observations, e.g. monitoring blood pressure and blood sugars; and supporting hospital appointments.
Social participation	Supporting patients to go shopping and access groups and clubs. They also help with voluntary work that patients do, providing patients with company and helping them adopt distraction techniques.
Therapeutic roles	Teaching anxiety management and relaxation skills, helping to build confidence, undertaking graded exposure activities and supporting pre-assisted therapy.
Activities of daily living	Providing personal care, teaching cooking skills, dealing with household bills and paperwork, liaising with other services, delivering specialist training to homecare workers and arranging emergency respite.
Accommodation	Helping with accommodation moves, arranging pet care during hospitalisation and supporting search for new accommodation.

Monitoring	Assessing adherence to and effects of medications and monitoring any signs of self-neglect

In addition to the duties outlined in the table above, support workers have a moral duty to protect people when they are weak and vulnerable, helping them to strive towards healing and recovery, and ensuring the humanity of care (Goodrich and Cornwell 2008).

Also, due to the increasing amount of paperwork and other clinical activities faced by registered nurses, support workers are the ones who spend quality time with patients; therefore, they perform frontline duties, having the most contact with patients and their families. However, for many support workers, this independence can lead to feeling frustrated that they are giving 120%, yet they do not always feel valued as part of the team or by the organisation (Ford, 2021). Support workers, despite their duties, earn less than their qualified counterparts. The different pay bands are illustrated in Table 4.2 below.

Table 4.3. Different staff groups and their annual pay range

Doctors	**£80,000–£120,000**
Specialist nurses	£56,000–£61,000
Clinical leads	£32,000–£41,000
Newly qualified nurses	£25,624–£30,103
Healthcare support workers	£19,256–£21,000

From the table above, some support workers are delegated tasks that the newly qualified may be doing, yet they earn at least £4,000 less.

The next section will focus on the mental health trust chosen as the research setting for this thesis, including its place in the NHS structure, provision of mental healthcare and care for its workforce.

4.4. The Trust (research setting)

4.4.1 Place of the Trust in the NHS structure

The Trust is one of the largest NHS mental healthcare trusts in the North East of England. It was founded in 2006 through the merger of three different NHS Trusts. It was given Foundation Trust status on 1 December 2009. By becoming a Foundation Trust, the Trust is able to provide people in its local communities the opportunity to have a say in the way services are provided. Generally, an NHS Foundation Trust has members made up of local people and staff, including patients and carers. The Trust's Board of Governors represents the interests of the members and partner organisations in how the Trust is run. This structure therefore gives NHS staff and communities a bigger say in the management and provision of Trust services in their area. Subsequently, the NHS Foundation Trust can direct its services more closely to the communities.

The Trust strives to put its vision, values and mission at the heart of everything it does, without being too controversial. The Trust vision was established in consultation with service users, carers, staff, governors and other partners (Trust Intranet). The values of the Trust are centred on showing care and compassion; focusing on recovering; being respectful, honest and transparent; going the extra mile; and valuing and working together with partners.

The Trust's emblem is to ensure that it tries to provide the best care, by the best people, in order to achieve the best outcomes. In addition to this, the Trust strives to ensure quality and safety are at the centre of all it does, and to ensure that its values are reflected in everything it does. The mission of the Trust is to be able to deliver services of the highest quality that consequently enable and empower service

users to not only reach their potential but to be able to live fulfilling and independent lives. Even though the Trust is run locally as part of a Foundation Trust, it remains fully part of the NHS. As a result of this, its main purpose is to provide care and services to service users and patients, including their carers, based on the core NHS principles (providing free care, based on need and not ability to pay).

The Trust is comprised of NHS England and NHS Improvement Teams responsible for the quality, financial and operational performance of all NHS organisations in the region; and sustainability and transformation partnerships (STPs) aimed at bringing together NHS providers, local authorities, commissioners and other local partners to plan services based on the needs of local communities. In some areas, integrated care systems (ICSs) have evolved from STPs; they are responsible for managing local resources and improving healthcare for communities. Integrated Care Partnerships (ICPs) are providers that work together to provide care, such as hospitals, mental health services, community services and GPs. Finally, there are Primary Care Networks (PCNs) responsible for providing primary care.

In 2015, the *Health Service Journal* named the Trust as one of the top 100 NHS Trusts to work for. More recently, the Trust was chosen by NHS Improvement to lead the way in mental healthcare as a strategic partner in developing its mental health improvement programme. Also, the research Trust is accountable to various Commissioners Foundation Trust members; these are local people in the community, including patients and NHS staff. Like any other NHS Foundation Trust, decision making has been moved from the central government to local organisations and communities. The reason behind this change was to be able to respond adequately and in a timely manner to the needs and wishes of the people they provide services to. Consequently, the Trust is not under any direction from the Secretary of State of Health; instead, it builds stronger connections with its local communities as part of what it does.

However, the Trust is faced with uncertainty as a result of the continuous ongoing changes in the NHS, such as restructuring. Most of these changes are brought about by financial pressures caused by austerity and budget cuts; as such, the Trust sometimes struggles as demands for many of its services are rising and public expectations are becoming higher (Trust Intranet). This will be discussed in more detail in Chapter 5 of this thesis.

The Trust anticipates challenges in the future as the NHS strives to continue to provide high-quality services and live up to the expectation of patients and the public. The Trust also envisages that the next five years will be a period of change both for itself and the wider NHS. The changes anticipated are in clinical needs and levels of acuity for patients. People are living much longer, which is of course good news; however, an ageing population presents several serious challenges for health and social care services, including mental healthcare (Trust Intranet).

4.4.2 Provision of mental healthcare in the Trust

In terms of provision for mental health, it appears from the Trust's Intranet that things are done well, so it is possible that the local Trust may be organising mental healthcare differently than other Trusts. This is reflected in its structure; the services it provides are organised geographically into what are known as Locality Care Groups. There are three groups: the North, Central and South localities. The aim of this structure is to provide and improve patient care by focusing available resources on areas that add value to patients and strengthen clinical leadership across the Trust. Within the geographical boundaries of the Trust, mental health provision is assessed by several additional service providers: local authority social services, Primary Care Trusts (PCTs) and the voluntary sector. PCTs are administrative bodies responsible for assessing the local health needs of communities, including commissioning and providing care. They are now at the centre of the NHS, controlling 80% of its budget (NHS Digital 2021).

The Trust is served by six PCTs which are grouped into two Primary Care Organisations (PCOs) and are an integral part of the communities they serve. One of the Trust's strategic ambitions is to enable people, their carers and communities to better manage mental illness, including disabilities and their precursors. Another important strategic ambition of the Trust is to ensure that its mental health and learning disability services are sustainable, delivering real value to the people who use them. In addition, mental healthcare in the Trust is provided both in hospital (inpatient) and in the community.

For the provision of mental healthcare in the community, care across the different localities listed above is delivered to ensure that community services work alongside other partners and agencies to ensure that the needs of patients and the

people they serve are met. On the other hand, the Trust has a number of inpatient wards. Care is provided in inpatient units every day of the week, within the constraints of the resources available to the Trust. The wards are comprised of Psychiatric Intensive Care (PICU), learning disability wards, forensic services, neurological services for patients with brain damage, children and young people services, rehabilitation wards and specialised units for people with dementia. People with an acute mental health problem may benefit from time in hospital as inpatients to help them recover.

4.4.3. Care for the workforce

Currently, the number of staff who work together to provide care within the Trust is approximately 6,000 across all the staff groups and on a daily basis, they deliver a diverse range of local, regional and national services. On its Intranet, the Trust, like most organisations, claims that its staff are its greatest asset. Yet there is recognition that organisational needs determine where staff work, how they work and who they work with, and this can be stressful for people. As Chapters 5 to 7 will show, research participants were critical of the care for the workforce that they experienced.

However, there is still a shortage of qualified nursing staff across staff groups, and current workforce shortages are taking a significant toll on the health and wellbeing of staff. Considering the current shortage of staff across the NHS, it is predicted that by 2030 the gap between the staff needed and the number available could reach 250,000 (Beech et al. 2019). It is in this context that the Trust claims that every member of staff has a vital role to fulfil and makes a valued contribution to the services they provide.

Given obligations under the Health and Safety at Work Act, the Trust attends to its duty of care to all staff through several policies and procedures such as its sickness absence policy. It is thought that staff requiring workplace assessment to determine their role and fitness for work will be provided with specialist advice and support, and in cases where issues cannot be resolved at a local level, the input of Occupational Health is sometimes required to provide expert advice and recommendations. The Trust has a fast-track service for stress which enables employees to be referred to the Employee Health and Wellbeing Service. This works

by signposting staff within 48 hours to the Trust's Early Intervention Team if citing stress as a reason for going off sick. Although there is a robust policy on managing sickness, there seems to be dissatisfaction among staff regarding the way the policy is implemented.

Furthermore, the Trust's Organisational Development unit has put in place strategic aims which endorse the Trust's commitment to support the wellbeing of staff and to view its employees as "whole persons", which means having standard support systems and mechanisms in the workplace. Examples include the staff wellbeing group and the Trust's occupational health.

The Trust (PGN 2018) also states in its support policy that it strives to recognise its staff as "experts", in addition to valuing their mental health lived experience. The support policy guidance implemented by the Trust aims to improve workplace culture by encouraging staff and managers to talk about their mental health, to raise awareness of the support available and to alleviate the stigma associated with mental health issues (PGN 2018).

The support policy acknowledges that when staff feel good about themselves, they work productively, interact well with colleagues and make valuable contributions to their team and the workplace in general. In terms of promoting wellbeing among its staff, the Trust on its Intranet claims to be working in a new devolved model which actively encourages discussions around the role of line managers being the key in promoting the mental wellbeing of employees through a supportive leadership style and management policies. The new model being developed also includes promoting a management style that encourages participation, mentoring, coaching and constructive feedback. This aims to ensure that policies for the recruitment, selection, training and development of managers recognise and promote these skills, making sure that managers are able to motivate employees and providing them with the training and support they need to develop their performance and increase job satisfaction. The intention is to increase understanding of how management style and practice can help promote the mental wellbeing of employees and keep their stress levels to a minimum, so that managers can identify and respond with sensitivity to employees' emotional concerns and symptoms of mental health problems. This will ensure that managers can understand when it is necessary to refer an employee to

occupational health services or other sources of help and support, even when the employee is not on sick leave, and that they value mental health lived experience.

Below, for the purpose of this research, I will list some of the Trust's policies that are relevant to this study.

Table 4.4. Key organisational policies

Workforce policies	Aim
Managing sickness absence	To provide a supportive framework and procedure to ensure that employees' individual circumstances and needs are considered.
Stress risk assessment	To identify what needs to be done to reduce stress in teams.
Sickness absence trigger points	To address any noticeable pattern of absence giving cause for concern.
Flexible working	To help staff achieve a better balance between their work and home lives, as well as to improve service delivery through a flexible workforce.
Supporting mental health in the workplace	To reduce and tackle sources of stress and promote the wellbeing of all staff.
Disciplinary policy	To set out guidance to employees on expected standards of behaviour and provide procedures for addressing issues where a staff member fails to

	meet the required standard of work conduct.
Guide to flexible working for managers	For managers to be able to engage in open and honest conversations with staff and offer support relating to flexible working.
Guidance for managers stress risk assessment	To provide advice for managers on how to conduct a stress risk assessment both for teams and individuals. An approach aimed at preventing stress before it occurs.
Relationships at work	To ensure that working relationships are harmonious and that bias does not influence managerial decisions.

The Trust's strategies include caring, growing and discovering together, developed in partnership with patients, staff and carers. In setting these strategies, the Trust has considered both national and local approaches relevant to the people using its services. These strategies relate to my current research, which therefore makes the Trust an ideal setting for my study.

4.5. Concluding Remarks

This chapter has looked at provision of mental healthcare in the UK and in the NHS, including societal concerns and problems associated with mental health issues, including media coverage and the societal and economic costs of mental health. The NHS as an organisation and its structure was discussed. The role and duties of mental health support workers, who are the participants for my study, was also highlighted in order to understand their experiences in the workplace. There is little funding available

to mental health services compared to other health sectors and although there is emphasis on allocating funding to support financial sustainability and improve performance, the gap between the growth in funding for NHS mental health providers and that for NHS acute providers still remains. In addition, there is a lack of skilled workers and shortage of staff across all staff groups in mental health services compared to other healthcare settings.

The research setting for this study was also extensively discussed, including the place of the Trust in the wider NHS structure; the provision of mental health services in the Trust, which include both community care and inpatient services and care for its workforce; the challenges and changes anticipated in the future; and the implementation of its support guidance policies for its staff, such as the sickness absence policy.

The next chapter is the opening of the results section. This chapter provides the findings of the research from the interview data, ethnographic field notes and my own interpretations.

Chapter 5. Organisational domain

5.1. Introduction

Chapter 2 of this thesis highlighted a lack of current understanding of what causes stress for mental health support workers, what their job role is and who they really are. Data were derived from interviews and ethnographic field notes that were coded as belonging to the organisational domain. In social constructionist research such as this study, the researcher has an important role to play not only in designing the study but also in conducting it; after which, the data collected need to be presented in detail (Lincoln and Guba 1985; Patton 2002).

In this chapter, I will discuss the key stressors from the organisational domain. I will be using key reported themes and categories that I have inductively identified from the data.

The first section briefly highlights the role and duties of mental health support workers within the NHS to provide a useful platform to consider how the organisation might play a role to mitigate the effects of work stress. Details about the NHS as an organisation and its staff have been discussed in Chapter 4.

The following section discusses the key stressors from the organisational domain and the reported themes and concepts from the data analysed, including organisational change, uncertainty, resource constraints and fear of losing one's job. Each theme is reported in a dedicated section.

The accounts constructed by participants reflect their own interpretations and perceptions of who and what support workers are and the way they work. Participants came from various mental health wards and from a variety of backgrounds, including HR staff, ward managers and clinical team leads (see Chapter 3, Section 3.4). It was important to recruit diverse participants because this helped me to get a detailed explanation and ascertain other views from people with different clinical roles, and then to compare these findings to ascertain if they had a common ground.

It was interesting to note that common themes emerged. Previous experience and how long workers had been with the Trust seemed to have a major impact on the answers that were provided during the interview process, so I decided to take into account their

past experiences and the primary motivations of participants as reported during the research interview.

5.2. Change, innovation and efficiency

The NHS is constantly changing (King's Fund 2017). Hence, working for the NHS can be very challenging because every day brings it with it new challenges. Some of the current challenges include pressure faced by mental health and wellbeing services, staff absences, health inequalities (Ham 2020) and policy changes requiring new practices and adjustments (Lumbers 2018). This research acknowledges that organisational change can bring about positive impact to the organisation; however, it can also add pressure to the way workers work, especially with respect to the modern NHS.

Staff mentioned that the changes act as an additional stressor and put pressure on different groups of workers. The quote below is about the effect of change on people generally in terms of pressure, an increase in form-filling, and new ways of working:

> I think that staff feel that they are doing too much and there aren't enough hours in the day. I think it is a very difficult machine and people don't understand it because they think if Sainsbury can be efficient then why can't the NHS? These poor people are working in the NHS because they wanted to care but there is immense pressure as a result of constant change – there is paperwork, there is worry about CQC (Care Quality Commission), and have you done your appraisal, and have you done your mandatory trainings? I mean how many times have we screamed when we do our e-learning and you feel like a bad person for getting the answers wrong? It is stressful. – P31 18/09/2019

The above quote was from a ward manager in relation to support workers.

> The changes are not helping in any positive way; there are so many new innovations and restructuring going on and our organisation is complex on its own being that it is healthcare all these changes only place pressure and stress for the different group of workers not just us support workers who all play a role in service delivery. – P27 22/04/2019

On the other hand, the quote below is about the effect of change on working practices. Research participants recognised change as a stress factor resulting from constant

organisational restructuring and changes to work environment which brings about staff rotation:

> "I understand the Trust will always be restructured; therefore, unplanned staff rotation is eminent. However, sometimes, there are also changes in our work environment which staff are not prepared for and this causes a lot of anxiety and stress for everybody on the long run". P2- 18/04/2019.

The key areas of change identified in Chapter 4 of this thesis affecting healthcare workers include restructuring of the Trust, changes in management and changes in how things are done within the organisation.

Mental health support workers are in a job that is both physically and emotionally challenging; research suggests that they often work in an understaffed environment, leading to work-related stress and high turnover rates (Leka et al. 2014). It is therefore not surprising that they expressed difficulty across the clinic once they were protocoled, as seen from this respondent:

> We are understaffed, and I think it is difficult for the whole clinic and on top of the pressure and stress this causes for people, you see staff been sent from their base wards to other wards (protocoled) to help out. These are wards they are not used to. If stress is to be managed, then the Trust needs to staff the wards accordingly. – P27 29/07/2019

To support the quote above, during a night shift I observed a member of staff who was clearly distressed having this conversation with a colleague:

> I have come to work tonight thinking I will get to work on my ward. I was protocoled earlier in the day before coming in without notice and without anyone checking if I will be happy to work on the ward I have been sent. My anxiety is over the roof now due to not knowing what to expect on where I am going and the risks I will be put into. This is stressful and it is one reason why people do not want to come to work. Diary entry 13/01/2020

There appears to be a perception among senior management that innovative solutions to cut costs and improve savings are needed to improve the quality of care. The associated changes to working practices have a real impact on people's lives, their work and wellbeing. This means that change can be difficult for people, irrespective of the result or how beneficial the outcome may be. This is noted in the following excerpt from my field notes:

> A discussion by some staff members states that personal wellbeing was being impacted by organisational changes and even with the changes, desired results are not achieved sometimes. Instead, the complexities of delivering change across the organisation is leading to stress and absenteeism. – Field diary 10/07/2019

The point above is about how change affects the wellbeing of people. Change processes can lead to increased innovation and performance. However, change within an organisation may be associated with threats to employees:

> With this constant change, I think my job is on the line because you never can predict what was going to happen the next day, to be honest we feel threatened by it. – P1 21/07/2019

The point the participant above is making is about people feeling threatened that their job may be culled in the next restructuring.

The effects of recurrent change initiatives were visible in an interview discussion with a member of the Human Resources Department, who identified that there were people who were no longer bothered by their stressful situations. So, staff had given up on any support from the Trust, since stress brought about by constant change was beginning to have a massive impact on their wellbeing, leading to low levels of engagement with their colleagues and line managers:

> You have got people who have low levels of engagement and also report low levels of wellbeing caused by recurrent change. These are the people that are not bothered anymore and are stressed by constant change. Maybe they have seen everything change and things are different now after 30 years in the NHS. I would say it is all down to constant restructuring and innovations. – P8 HR 19/10/2019

The point also emphasises how people's motivation and morale suffer as a result of change. Similarly, a support worker expressed her concerns of wanting to leave the job due to the way things were restructured every so often, saying the only reason she wanted to stay was because of how much she cared about the patients. This can be portrayed as change being disruptive for workers as they feel isolated or unsupported when their social network at work is disrupted through restructuring:

> I have had thoughts were I just want to leave and get a job with Royal Mail as a postman; at least with that, I might not have to see so many changes as much as I have seen in these few years of working with the NHS. – P17 12/05/2019

Like the earlier point above, the point is about change impacting motivation, engagement and morale. The staff member is fed up with change and wants to have a job role with more stability in their working environment, which restructuring disrupts. Implicit in this quote, it seems that the person feels that they are not able to bring about a change in their immediate working environment that would make them enjoy their work again.

However, the quote below suggests that workers are now faced with more responsibilities through abolition of rules, when perhaps they are ill prepared to take more responsibility:

> I think over the years the rules on how you care for patients has changed. There used to be a structure to do with rules and now those rules are not in place anymore. It is more relaxed now and it is harder sometimes because you want your patients to do well but you can't push them towards the right direction. They have to find that on their own and unfortunately, they end up coming back to hospital for us to support them. The rules in place before were more effective than what we have now. – P31 18/09/2019

The quote suggests that previously staff had guidance through set rules, for example rules around planned and authorised leave for patients off the ward, promoting sleep patterns and encouraging independence. However, they feel that now this guidance is gone, which means that there is increased autonomy in decision making and a reduction of guidance.

With the invention of restrictive practice – an intervention that has the effect of restricting the rights or freedom of movement of a person with a disability – staff can never be quite sure if what they are doing is the right thing or if they might get into trouble by not getting things right. This in turn can create anxiety for staff and lead to stress:

> It has become extremely difficult to work with patients since the initiation of restrictive practices. I feel that most of the time we feed into patients' needs and wants, they are allowed to do what they like and how they like. People are no longer accountable for their actions, and they get away with unacceptable behaviours that used to be

> challenged in the past. Staff have taken a step backwards for fear of getting things wrong and the ward environment can get very stressful as a result- P4-19/06/2019.

In addition, people refer to generational issues – that is, a workforce that is made up of people from different generations – as being stressful. It is perfectly normal for organisations to have a workforce made up of people from different generations; however, this change of having “old timers” and “newcomers” can be difficult, thus leading to stress:

> There is generational difference within the workforce now, so you have got different generations who have different external factors erhmm so for me the biggest change is there are so many personal complexities now not necessarily more work issues. There is stress at work, there is high demands in jobs, there is exhaustion, there is environments that are busy, and they are busy all of the time where is the respite? – P23 - 20/07/2019

Similarly, some participants raised their concerns about the Trust getting bigger and merging with other Trusts. In essence, organisational change – merging with another Trust – has made the work environment more anonymous and there is reduced capacity where it is needed most in relation to patient contact:

> The size of the Trust is massive, it is difficult to navigate the different localities in terms of resource constraints exacerbated by organisational change and this may be impacting staff negatively- P32- 04/06/2019

Some participants felt that most of the changes implemented by the Trust had not been necessary at the time, and they did not seem to see such changes as beneficial. This is a cognitive component which involves what one thinks about the change:

> Some changes are just not relevant and do not seem to benefit anybody, not even the patients. We have recently been introduced to what is called restrictive practice, those high up seem to think that this is for the good of the patients but in actual sense it has caused more stress to everybody, and we often find ourselves complaining and asking if this was beneficial at all. – P19 -20/09/2019

Change has meant a reduction in staffing levels. This has resulted in people having to take on more work, which in turn increases their workload and causes stress:

> Things have changed quite a lot over time, change has brought about so many negative things e.g. staffing levels. – P12 21/09/2019

One worker felt anxious and angry about changes that were brought upon them suddenly. So, change communication and how changes are relayed is important because this can have an impact on how an employee may be feeling and how they might handle the situation:

> I was rotated suddenly from a medium secure ward to a high forensic unit with PD (Personality Disorder) patients. I never had any prior knowledge about PD and during the process of making the decision to rotate me, I wasn't consulted and didn't have any say. I was angry and anxious at the same time but there was little I could do. This obviously caused me stress because this change for me was huge and I had to go on sick leave to get my heard around things. – P18 20/09/2019

Aside from staff being rotated between wards, the day-to-day work environment and the kind of patients that are admitted to the ward can be unpredictable. This uncertainty leads to stress:

> I mean the uncertainty that comes with our role at the moment is complex … you are assigned different tasks outside your job description and most of the patients have complex needs and it is uncertain nowadays what sort of patients would be admitted. This uncertainty leads to stress. – P8 13/05/2019

> You hear the NHS is in crisis, people fear for their long-term future thinking whether they will be in employment this time next year. It is this uncertainty that leads to stress. – P4 19/06/2019

Staff know about the policies and activities implemented behind the scenes, including the five-year forward view, the transformation and sustainability plans and the new models of working; even the fact that there are plans does not sound reassuring to staff. Rather, it represents distant bureaucracy (Imison et al. 2016), thus creating fear among staff, especially for their long-term future. While it can be difficult to predict what happens within the work environment and how a typical day changes for staff, it is important to acknowledge that the nature of the work within a caring profession such as the NHS can be challenging (HEE 2020).

In summary, change seen in the Trust causes stress for people and creates uncertainty because it affects working relations and puts pressure on people in different ways; for example, by being disruptive and increasing uncertainty. Despite the effects of organisational change and its impact on the employee and the organisation, mental health support workers involved in my study all reported a strong, shared and caring responsibility based on a desire to help service users in any way possible. The myriad of changes introduced to structures and working practices over the last decade have affected staff in a number of ways. The analysis indicates that research participants appeared to be affected by the ongoing changes to structures, policy guidance and working practices.

5.3. Resource constraints

The resource constraints facing the NHS in terms of infrastructure and staffing levels were discussed in detail in Chapter 4. In this section, I will be discussing the main themes associated with resource constraints. These include inadequate funding, understaffing, lack of rest breaks and additional training. Asking staff to do things beyond and above their limit when there are no sufficient resources to facilitate this can lead to too much pressure and cause stress:

> We haven't got the resources; we need more resources. We are asking staff to do things above and beyond their limits, so it is re-evaluating the requirements and then putting the proper staff in and supporting them with the requirements which I know there is a piece of work going on currently, but it puts too much pressure on people and causes stress. – P17 26/04/2019

> There is a lack of resource in our teams, so you mentioned before when we talked about our locality and it is massive, and we don't have enough intervention erhmm from ourselves … I am telling you that as a Trust, we are massively under-resourced. – P16 26/04/2019

The following diary entry shows how a lack of resources is impacting patient care and causing stress for staff:

> There is not enough resources to look after patients and this lack of resources is impacting on patient care. Patients who should be on acute wards are now admitted on rehabilitation wards due to lack of acute beds. There are less acute beds than what we

> had 10 years ago, and this is impacting services. It is also causing stress for staff and impacting patients negatively. – Field diary 08/05/2019

5.3.1. Financial pressures

In the context of the funding gap detailed in section 4.3.3, the NHS remains low in budget. This leads to trade-offs and resource constraints, subsequently leading to increased pressure among staff.

From the organisational point of view, there seems to be increased financial pressure; this affects the Trust and at the same time impacts on staff. Occupational health professionals interviewed for this study believed that the services they delivered were not very effective due to tight budgets; as such, there were still high numbers of sickness absences. Funding constraints affect the resources available for staff wellbeing, for example through occupational health:

> The Trust obviously works on a budget so they only spend this much on occupational health services and so we design and structure the occupational health service for the Trust based on the tight budget and obviously we try and deliver as much as we can in that budget which to me is not enough and so there is still high numbers of sick leaves and absences so yea it is be quite very complicated but that is probably the basic terms I have to put it. – P10 05/04/2019

> For us personally, there is a lack of resource in our teams, so you mentioned before when we talked about our locality and it is massive and we don't have enough intervention erhmm from ourselves, that is not from the lack of trying because we are probably working at 200% erhmm and we have to think about our own health and wellbeing, but we are massively under-resourced as an HR team. – P7 14/04/2019

Participants also discussed how funding constraints impact how vacancies are filled:

> We can create roles we can create vacancies, but it is all tightly controlled in the NHS, and everything comes down centrally from the government. My experience as occupational health staff has shown me how much pressure and stress this has caused everybody. – P34 Occupational Health 10/06/2019

The comment above suggests that tight budgets have an impact on vacancies being filled. In other words, even when vacancies are created, funding is controlled by the

government and this in turn creates stressful situations for people. P34 also highlighted the competing priorities for funds, particularly NHS-wide campaigns such as the flu vaccination programme, over more local needs:

> The money for flu for instance is not new money to an NHS Trust it is money they were promised but withheld if they don't meet target … this is my cynical bit, I understand from an infection prevention control point of view why we need 75% staff vaccinated because it protects staff and it protects patients and that is a very serious issue but the cynical part of me feels like you know it's like there is pressure on staff to get the vaccine and if the Trust doesn't meet that target, it doesn't get its money. – P34 10/06/2019

There is a lack of access to equipment that is central to people's ability to do their job. This influences the experience of stress in the workplace:

> We are having issues at current time in inpatients services, and this is causing a lot of stress for staff. My admin doesn't always have access to a desktop computer. Sometimes, they are asked to work on a laptop and pushed into a corner, erhmm whereas for me, admin, their job is solely on a computer, so that piece of machinery should always be there for them. I appreciate the nurses also need to work on the computer but then there should be a computer there for them to use as and when they need to but that's not selling a half-hour shift, it could be an hour but to ask my admin side to step aside and wait, it's not acceptable. – P32 28/05/2019

> There is things that you want to do and these things you can't because we are prioritising priorities, erhmm the services are so big so across four CBUs (Central Business Units) we are constantly busy with a lot of pressure the services within the CBUs is massive and everybody wants you, everybody needs a piece but there is not enough pieces going around. – P5 14/04/2019

This inability to obtain resources needed to perform well in the job can result in stressful situations, as the diary entry below shows:

> We work in community settings, and you would expect that as staff we have access to desks and computers. We need money to provide these things … Yes, we are provided with our personal computers sometimes but what happens when they stop working? Sometimes there is hardly anywhere to sit, this is stressful and is an added pressure. – Field diary 10/09/2019

People also reported struggling on the wards to get keys that provide access to all aspects of the wards as the number of available keys is limited. Participant 3 explained how seemingly little things like this can be stressful for people:

> Resources are never enough. The little available is misused for example, there are some wards without sufficient keys and forbs (small devices for unlocking secure doors) to go around the staff because a lot of these keys have been misplaced at some point by staff. Little things like these impacts on your wellbeing because our stress buckets are all different. What causes me stress might not cause the other stress. – P3 03/04/2019

However, P14 seemed to be of the opinion that it was not necessarily a lack of resources but that the available resources were not adequately assessed. P15 agreed that lack of money was not the issue and that there were resources that were not being used:

> I think we can always do with more money, and I think it is not around the resources that we have it is about whether we use them, and I say we have got all these resources at hand I just don't feel we are accessing them enough I think there is a lot of time wasted going in between services. – P14 26/04/2019

> I think there is not one thing I don't think it is about the money or the resources I think it is about if we are using them. – P15 26/04/2019

Both points above are in relation to distribution of resources, which is closely linked to the point about prioritising, albeit this time at a local level. The quote below from HR discussed how the Trust is massive with numerous services spread across the region, and even though things are needed within these services, there are not enough resources going round:

> As an HR function, there is things that you want to do and these things you can't do because we are prioritising priorities, erhmm the services are so big so across four CBUs there are other services within CBUs and everybody wants you, everybody needs a piece but there is not enough pieces going around, it sometimes feel like you are pouring from hand to cup and if you are then obviously nothing comes out. – P6 18/04/2019

In summary, funding constraints result in a lack of resources. They invoke feelings of insecurity about obtaining and retaining the resources necessary for meeting job demands amidst competing priorities for funds, thereby triggering stress.

5.3.2. Understaffing

As discussed in Chapter 4, the healthcare system is under pressure as a result of staff shortages, particularly noticeable in mental healthcare settings (WHO 2009):

> So, at the moment, erhmm I think there is the financial pressure which does impact on staff vacancies because vacancies are not filled as quickly in some areas and other areas are hard to recruit thus leading to staff shortages. – P35 21/06/2019

The staff gap and understaffing currently faced by the NHS workforce is a concern. There is an accelerating rise in demand for mental health services but inadequate supply of workforce to meet these demands; gaps are either filled with temporary staff or roles are left unfilled (King's Fund 2018). One worker emphasised that they do not feel safe when dealing with challenging patient behaviour, which is a major stressor for staff (see Chapter 6). This is exacerbated by staff shortages:

> You can feel frightened and stressed when you don't have the support that you need in isolated cases. People come to work and feel threatened in a few incidences, and it is not to do with the patients but with the lack of availability of support from staff in a ward due to staff shortage. So, this is something which probably should be addressed before people get hurt. – P20 02/05/2019

In addition, participants made a clear connection between understaffing and the consequences for safety, noting that safe staffing involved more than maintaining just the safety of patients:

> There is not enough hours in the day and staff shortages lead to people breaching policies and they are doing patient observations too long. To me this compromises safety for both staff and patients. – P2
> 30/07/2019

The quote below suggests that it is difficult to get work done amidst staffing difficulties. This is especially true when the work environment is busy, necessitating the use of bank and agency staff because regular staff are either off sick or are unavoidably absent:

> When the wards are short staffed then there is high stress levels and that is the main challenge we have with our Trust – constantly being short staffed. When the ward is short staffed, you have to put in extra effort to make sure the jobs allocated is done. Due to the fact that our patients have a lot of need and are very demanding, when we are short staffed, the people on duty put themselves at risk because they want to make sure everything is done and there is no cutting corners. We are dealing with human lives; it is not like a factory job where you say ok I can do it this way or that way. So, our main challenge that leads to stress is staff shortage. – P18 16/09/2019

This quote incorporates many of the issues discussed in the chapter so far, notably staff shortages and financial pressure leading to resource constraints. The pressure of understaffing on individuals appears to be affecting their ability to continue with their role, thus making them ill:

> Most people left nursing because they were sick of being understaffed; it is a real shame. – P22 04/05/2019
>
> The few staff left on the ward are completely overwhelmed and bombarded with pressure and visions they can only "put in their box" and are in desperate need of mental health resources. – P1 24/03/2019

From literature, it is suggested that the mental health workforce has not kept pace with the demand for mental health services (Barker et al. 2019). One research participant highlighted how permanent staff were made redundant and replaced by agency staff:

> The Trust does not employ enough staff, they got rid of people years ago attributing it to cuts and then ended up spending twice the money on agency staff. Where is the logic behind all of these other than creating stressful situations for staff? – P23 05/05/2019

Some of the clinical leads (registered nurses at band 6 level, a step from becoming eligible to take up a post as a manager) highlighted the level at which jobs were created rather than the overall number of staff. They felt that because of their

administrative and mini-managerial responsibilities on the ward, it would have been ideal if they were not counted in the staffing numbers for each shift. However, they reported that staffing levels were not decided by the ward but by top management:

> I would like that clinical leads are not included in the staffing numbers during shifts because we have too much to do and you don't have the protective time to do all your jobs. The Trust is understaffed, and I don't think that there is ever going to be a change with this … I think that my perception of that changed when I came here as a clinical lead whereas in my former ward, I always use to think that we were understaffed and I always wanted more staff and I just couldn't understand why we couldn't get more staff but it doesn't just come from the ward level, it comes from higher above. – P9 10/07/2019

Most of the time, especially during increased clinical activities, the work demands exceeded the number of people within the team to meet the demands:

> The only downside is there is not enough staff and support to manage for when an incidence occurs and in the moment of things, there is no time to reflect, you feel emotionally vulnerable because you are so stressed and burnt out. – P3 12/06/2019

One participant identified how the issue of understaffing has been an ongoing problem from an organisational point of view, causing stress and putting more pressure on staff. He also added that inability to balance work and life commitments is one of the reasons why staff cannot be retained:

> For me the stress is generally lack of staff and working on numbers … the NICE [National Institute of Clinical Excellence] guidelines use to say one staff member to three patients, but we never get that … where are all the staff? – P23 10/05/2019

The above quote suggests that sometimes, the required minimum staff are not available. Similar to P23's earlier quote above in relation to people being made redundant, P11 suggested that one reason why the Trust is unable to retain staff is that people retire and yet they are not replaced. Of course, if there are staff shortages in the NHS, the Trust will also be affected:

> Shortage of staff has been an ongoing problem not just in our Trust, I would say the NHS as a whole; they can't recruit staff properly, they can't even keep staff. Most of the time this is due to staff unable to balance work and life. They let people retire

> and not replace them. They have lost loads of good staff including qualified nurses and they never replace them. – P11 29/07/2019

As highlighted in the interviews, unfavourable working conditions can play a part in people leaving a “profession” but for most, it is something they signed up for. In other words, NHS staff work long hours and shift patterns. This might make it difficult for people to commit to work in the long run, and hence it may be difficult for the organisation to retain its staff.

The comments indicate that understaffing is contributing to stress among staff, which can also have implicative consequences for the NHS, for example its ability to adequately maintain patient and staff safety. Indeed, the literature has suggested that the mental health workforce has not kept pace with the demand for mental health services (Barker et al. 2019).

Mental health support workers are indeed in a job that is both physically and emotionally challenging, and as suggested by this study, understaffing is adding to this challenge, contributing to experiences of stress:

> When the wards is short staffed then there is high stress levels and that is the main challenge we have with this Trust-being short staffed and when the ward is short staffed so you have to put in extra effort to make sure the jobs allocated is done and because our people are those in high need and very demanding so when you are short staffed, those of you on duty you put yourself at risk because you have to make sure everything is done there is no cutting corners because you are dealing with human life, it’s not like a factory job where you say OK I can do it this way so mostly the level of staffing that is the main challenge that staff have to deal with. – P6 12/07/2019

A participant suggested that adequate staffing levels and having decent rotas in place would help reduce stress in the workplace considerably:

> Well most of the time, we should have one or two people more on the shift but we don’t; we have a good ward but for whatever reason, staffing levels drops and then people become overstretched and stressed and become frustrated … there should be descent rotas in place to address staffing issues because this would reduce stress to a large extent … so understaffing that is the main thing for quite some time now. – P15 05/06/2019

The above points show that overwork and understaffing appear to put pressure on people in that they struggle to get things done, especially when looking after patients who are very demanding.

However, the quotes below can be couched in terms of stability of the ratio of permanent staff and agency staff. Ideally, permanent staff would create stability in the sense that they know the routines on the ward and can help those who come to cover like bank or agency staff. However, for those who do come in to cover, there is a lack of stability because they will automatically spend part of their time and energy trying to understand what is going on, the type of patients admitted on the ward including their risks and presentation, where things are kept, how things are done and who is in charge:

> If you are familiar with the patients is better. It cannot be avoided using agency or bank staff, but it is important to pair a familiar staff with them to support each other otherwise the stress this causes is unbearable. – P12 21/09/2019

> Unfortunately, most times the wards may be working with agency and locum staff who are unfamiliar with the ward. This always increase stress and pressure. Also working without the staff, you need I think is an added pressure and creates room for stress. – P31 18/09/2019

> I have had quite few security issues with agency staff, leaving doors open, falling asleep with doors unlocked, people not telling us where they are, honestly that kills the living daylight out of me because I have to worry about all these issues, keeping them and patients safe. This is stressful. – P20 21/07/2019

The quotes above are phrased in terms of staff stability and composition in work teams, which is a direct consequence of staff shortages. From my experience at work, for any ward to work well and avoid putting too much pressure on people, unfamiliar staff should not be left on their own when on the ward to cover shifts because they might not be familiar with the ward and how things are done. Rather, they should be paired with regular members of staff who know the ward and know the potential triggers that lead to incidents. Due to the current situation with staffing levels in the NHS, using bank and agency staff cannot be avoided, but it is important to

acknowledge the fact that they can be an additional stressor for staff; hence they should be supported to understand the ward.

In summary, understaffing causes difficulties across different staff groups due to inability to meet the demands of the ward environment, which can be very challenging. Staff constraints leading to increased work expectations are contributing to an increasingly difficult working environment for staff. Some people have been forced to retire due to unfavourable conditions; these play a part in people leaving a "profession". However, for most people, it is what they signed up for. Also, working long hours amidst staff shortages exacerbates difficulties in retaining staff. The Trust should ensure that vacancies are filled, especially when people retire, rather than depending on bank and agency staff.

5.3.3. Development opportunities

Some research participants reported being comfortable with the levels of training they had, and were quite happy to renew them every year to continue their professional development and stay up to date with their competencies. A member of staff also highlighted that he felt satisfied with the current training provided by the Trust because he had no intention to progress from being a support worker to a much higher post:

> Yes, my trainings are enough because I do not want to progress further, I am happy where I am in terms of the level of trainings and if any more were to be added this will become a bit too much and stressful for me. – P30 26/05/2019

Another worker reiterated that he was comfortable with the level of training provided and expressed his dislike for training:

> No, I would not want any additional trainings, I hate trainings … the trainings we have is just about enough to be honest, it is already stressful as it is because you have to renew all your mandatory trainings every now and again and it just burns you out every time. – P29 25/05/2019

A more prevalent sentiment among participants was a desire to have more training and development, particularly around issues of resilience. Resilience training teaches staff how to recover quickly from difficulties and challenges. Since mental health support workers' jobs can be quite challenging, it was no surprise to hear requests for more training:

> I would love more trainings around resilience … this is one training I have been looking forward to having because the nature of our job requires us to be resilient. With this training I believe the number of people going on sick will reduce to an extent. – P27 22/04/2019

> I would have loved trainings that are opt-in for example resilience trainings. This training is particularly important I think due to the nature of our jobs. – P1 21/07/2019

> I think that potentially we would look at further training on emotional resilience, the course came out recently and I don't know if you know it filled up within a week, so the course came out and I tried to test it so I get feedback to give to the staff to say that I have been on it and all the dates went within the first week of it being issued so I think we have got a capacity issue in terms of rolling out the resilience training. – P25 21/08/2019

Other participants spoke about a need for more skill-based training to better equip themselves to face the challenges of working in a challenging healthcare environment. This point seems to be particularly important for bank or pool workers, who regularly work on different wards and/or with different teams to provide additional staffing from time to time:

> I have always asked my manager to get me booked onto any additional trainings that may become available because as a bank staff you never know what to expect on the ward that you would be going to for your shifts. Every day is different and sometimes additional skills are required, I become stressed when I don't know how to handle a certain situation. – P2 18/04/2019

Others who were pool staff with a substantive post but were protocoled to different areas of the Trust to cover shifts felt they needed more training in case they were sent to areas that needed additional skills to carry out their duties. For these people, not knowing what might happen on a ward where they were sent to cover shifts could lead to stress:

> As a pool staff, you get sent to any ward within the Trust and you need to be prepared for what the day brings, I was once put in a position where an emergency response belt was needed to deal with an incidence on the ward, and because I wasn't trained to use I couldn't be of any help and the other members of staff apparently appeared stress by this because they needed more hands and this made me feel really anxious. – P23 20/07/2019

These people may be facing additional uncertainties, for which they report feeling ill prepared.

Qualified nurses also reported a notable need for additional structured and in-depth training in specific areas. The provision of training and development/CPD in the Trust is normally in person or through e-learning. However, since the Covid pandemic, most training is now done virtually, typically through Microsoft Teams. Staff are mandated to complete their training, especially the mandatory classes, but additional classes are difficult to get into because they are not accessible, and people may need to obtain permission and authorisation from the line managers to get into them:

> I think more in-depth trainings around specific things like medical transcribing, it is something that has been on my mind for some time now and the more I think about it the stressful I become. I have spoken with my manager, and she insists there is not enough funding at the moment for it so I would have to just sit and wait … it is stressful for me. – P22 02/10/2019

> Yes, I would love more structured trainings on personality disorder and more on physical health specifically working with people with neurological disorders, I have just been protocoled down here a neuro ward and it causes you anxiety when you don't know what to expect sometimes. – P5 19/06/2019

An HR emphasised the need for managers to be provided with additional in-depth training, especially in the area of management. They reckoned that a newly employed manager might not have the required people management skills and experience to manage a group of people, which could lead to stress for both managers and staff:

> I think we need to provide management trainings for managers so as soon as somebody was appointed, we have management training programme that managers go on high level, I find it quite high level and it doesn't get into the nitty gritty. When I attended it and I am an HR manager, I came out with some of my questions whereas that should have been my bread and butter so if I am going in and coming out with more questions, and this is my bread and butter how can I expect a newly employed manager with no people management skills and experience to recognise actually that they have some questions and I am doing stuff myself, I don't think anybody else in HR is doing it cos I did it at XX; I have developed a little mini management programme so every time one of our staff in pharmacy gets appointed as a newly qualified manager, they do a management induction programme and I sit with them one day a small cohort of managers. – P29 21/10/2019

> Erhmm, we don't have enough trainings for our managers we definitely don't, and I think you will find that it is a consistent theme, I don't think that's an [anonymous] Trust thing I think that it is an NHS thing in general. – P28 15/08/2019

> There should be more training for managers especially in areas of stress risk assessments, mindfulness, and group CBT including wellbeing. – P8 22/04/2019

From the quotes and discussion so far, it is evident that as people progress, they tend to take on more and more management roles, for which they may not be well prepared.

HR staff also noted that there wasn't enough training, attributing this to either a lack of trainers or lack of commitment from managers regarding staff training:

> I think that we don't have enough training I don't know if that is the training capacity or if there are not enough trainers or if there is a commitment there for managers to make staff attend training because there is that demand for trainings which would be very helpful. – P20 21/07/2019

Another participant was pleased about the yearly refresher mandatory training but would have wanted more training around personal development:

> I emphasise on my mandatory trainings because they will enable me carry out my duties effectively and I am pleased that these are provided yearly. But there are other trainings which should help you work efficiently on your job so I would have loved more trainings in personal development, but I find myself privately doing that at the moment. As a Trust, I think trainings on personal development should be offered as mandatory trainings because it will help us function effectively on our jobs. – P7 14/04/2019
>
> I would like to have some individual, professional trainings or developmental trainings rather than being elected for example a recognition of my degree where I have been trained on would have been helpful. – P11 16/10/2019

The findings from the interviews suggest that of particular importance is the need to provide training and support to staff and even managers, especially those responsible for delivering organisational strategies.

5.4. Organisational culture

This section will explore some issues related to organisational culture, such as manager-staff relationships.

My research findings identify the important role that organisational culture plays in the day-to-day role of mental health support workers. Interviewees described organisational culture as a system of shared values and beliefs which governs how people should behave and interact (P27; P8). They also expressed how it was a determinant as to how decisions are usually made. Some participants described managers as having a lack of understanding of the Trust's culture:

> My manager lacks the strategy to engage people in decision making. Her strategy most times clearly portrays her lack of knowledge regarding organisational culture … it is the reason why sometimes we find it difficult to achieve certain goals at the stipulated time. – P8 12/03/2020

> Personally, I think that management lacks basic knowledge of the culture of an organisation such as the NHS. If they understood the current culture of this organisation, then I assume that they would consider a lot of things when introducing changes and this ought to be communicated effectively. – P27 16/05/2019

Culture, however, is experienced and interpreted subjectively by people in the context of their own belief systems and their perspectives on the organisation.

Although the participants above suggested that their line managers did not know the Trust's culture, the main point is the apparent tension, either between different interpretations of the Trust's culture or a mismatch between culture and some behaviours. Participant 27's quote above suggests that there is a lack of communication of change to everyone in a team, which can have a negative impact on staff.

People reported that in the Trust, power and control were concentrated among the top management. These few managers were said to make quick decisions among themselves and to implement these decisions swiftly without consulting with those at the lower end of the organisational hierarchy. Participants further described the culture of the NHS as a system where power results from a person's position. In Max Weber's work on bureaucracy (Weber 1978), this type of power is regarded as authority. One

participant described this sentiment as the Trust having “too many chiefs and too few Indians”:

> There are too many strategies poorly implemented and this clearly doesn’t work sometimes … erhmm for example since the implementation of restrictive practice I have seen a lot of things go wrong. Yes, I want our patients to be least restricted as possible but the way things like this are implemented is what causes problem for everyone. Implementation of this may be in line with the organisation but it has only just been implemented and hasn’t been rolled out properly … it is clearly sometimes causing stress for staff because our hands are tied as to how much we can or cannot let the patients take on. – P12 15/08/2019

In addition to the findings from interviews, my field diary captured the role of power and how this affects staff dynamics on a day-to-day basis. Those on the same band level were normally at loggerheads with each other, wanting to dictate who should and should not take over certain activities of the day.

5.4.1. Lack of involvement in decision making

Mental health support workers felt that the way organisational culture was perceived and understood by managers’ limited involvement in decision making. Participants believed that they were not involved in decision making and felt undervalued in their role:

> Never been involved. At times I am made to feel utterly useless. I have no memories of ever being consulted on any matter. – P4 07/08/2019

Also, in decision making, some staff wanted their opinions to supersede those of their colleagues. They wanted to be portrayed as the best decision makers. This normally caused friction and many staff relationships had broken down as a result.

P18 said she had worked in this way for 20 years, giving her best to patient care, and not once had she been involved in decision making. She believed that support workers are, in her words, “underdogs who are not heard but only seen”:

> I have been a support worker on a ward and sometimes felt undervalued, spent 20 years of my life giving all I had to the patients in my care and yet not once am I being involved in the decision-making process. We

> really work hard out there and most of the time on our own, but I think the majority think we are underdogs, the little Indians that have their place seen but not heard. – P18 02/04/2019

Participants 28 and 13 described support workers as frontline staff who are not part of the decision-making process. They suggested that all health workers, no matter their position, should be listened to:

> In many situations support workers are at the extreme frontline yet they seem to be treated like no one sometimes … shame they won't be allowed to get involved in decision-making process. – P28 05/06/2019

> When it comes to decision making, we are not recognised but "it is the small cogs that help turn the big wheels" … all healthcare workers regardless of professional status should be listened to and involved equally. – P13 08/09/2019

> As mental health support workers, we are never really involved or mentioned anywhere not even in the media especially we are all working as a team and are in the front line but seldom recognised … it is a stressful situation because we are all part of the NHS, and we all play a part or so I think. We get left out in a lot of things I think erhmm … due to not being professionals. – P8 01/02/2020

The next subsection will discuss employee voice and recognition and the impact this has on mental health support workers.

5.4.2. Employee voice and recognition

The findings suggest that there is a link between a lack of involvement and a lack of employee voice and recognition. In one sense, they are two different constructs but, in the data, they are closely linked. Participant 19 mentioned being undervalued and argued that there would not be an NHS without support workers:

> I am a support worker, and I am thoroughly disgusted by the level of support available and angered that we aren't given the credit we deserve. I can do what the trained nurses do and we do more behind the scenes and for less pay. Sometimes I do feel undervalued; without HCAs (Healthcare Assistants) and support workers there wouldn't be an NHS … we are hardworking and bloody grafters. – P19 06/05/2019

Participants 10, 14, 2 and 3 also drew attention to the nature of the job performed by support workers. They described themselves as the “backbone” of the NHS and the eyes and ears of the ward, without whom the registered nurses would not be able to do their job. However, they felt left out when it came to decision making:

> Support workers are the backbone of the NHS, and they are always on the front line. Nurses couldn’t do their job without them and yet they wouldn’t be involved when it comes to deciding the best interest of the patients. – P10 05/06/2019

> Without support workers, the hospitals would crash and stop they are important members of the nursing team and deserves to be supported … it does not matter what your title is and this is with regards to any jobs … support workers or not we are all human beings. – P24 12/03/2020

> When the registered staff are tied up with admission, paperwork, assessments, endless office tasks we are with the patients – the eyes and ears of the ward, yet we are invaluable and do not have a say in anything. – P14 09/09/2019

> It has always been like this – the fact that we don’t get involved in important matters, but the wards wouldn’t run without support workers, HCAs, even domestics, porters etc. … all our hard work never ever get recognised. – P2 10/02/2020

> Everyone counts whatever their role is … everyone should be involved in the decision-making process they couldn’t do their job without the help and support of support workers or healthcare assistants … they all play an important role, and our rank doesn’t matter our commitment does and we all deserve to be supported when needed. – P3 05/10/2019

The expectation of recognition was shared across all participants. Participant 11 referred to support workers as the “unsung heroes” and the “foot soldiers” who should be treated with the same respect regardless of their band. People wanted to feel involved and engaged as part of the team:

> Everyone is entitled to their opinion and that opinion should count and each staff should get the same respect and treatment in the NHS no matter what your band, professional status or role is … but it doesn’t happen there is so much rivalry and snobbery … some get to a certain band and forget where they started from … with time, we would see who the heroes are and who should be getting the recognition and given the credit they deserve … we remain the foot soldiers and the unsung heroes. – P11 07/05/2019

Participants 15 and 17 were driven by a passion of caring for people and emphasised that all bands should be acknowledged no matter who they are or what they do. They felt that this was lacking in the NHS and caused stress for its workers:

> We all play a vital role in service delivery and that is caring for people … I have worked on a ward on my own with limited qualified staff and also worked on days as crisis team on my own too attending to crisis work in the community which could sometimes be very stressful … our support also revolves around helping senior staff; we are not asking for our names to be put forward but to acknowledge all grades no matter who or what they do and render them support for when they need it. – P1 10/06/2019

> Everyone is important whatever the rank from top to bottom we are all human beings looking after people in our own different ways … from the doctors down to the cleaners and porters we are all just as important as each other and are a team … we all deserve to be recognised and supported. This is clearly lacking in the NHS as a whole and leads to stress. – P17 05/06/2019

From the above excerpt, staff wanted some form of recognition and support regardless of their hierarchical position.

A newly qualified nurse (less than six months) pointed out that she noticed during her training and post qualification that support workers are not often given the same support as doctors and nurses:

> HCAs or support workers are "the backbone of the ward" … I learnt so much when I was a student nurse, they taught the fundamentals of nursing care … I had no idea what to do when I first walked in to the ward but they taught me all the basics with a smile on their face and kindness in their heart … these workers deserve to be recognised but they are not. – P16 04/08/2019

Another newly qualified nurse expressed concerns over a lack of support when she was a support worker. She described the role of a support worker as being like "a left arm". You could not function if it was not there:

> I was a support worker before I did my training and not for one day did I feel supported at all or get recognised for the work that we do … I have never forgotten my roots as a care assistant or support worker … it is like your left arm and as nurse, you can't do your job without them. – P22 07/08/2019

From my ethnographic field notes, it was interesting to note that participants felt they were neither supported by the Trust nor recognised by the media. They suggested that there was no recognition of who they are or what they do and the pressures they have to deal with in the workplace. Staff often expressed how they felt about a lack of understanding regarding their role and recognition by the wider public; they reiterated their importance and usefulness and the role they play in the NHS, including the kind of patients that they look after. These responses tallied with my field notes:

> There is a lack of understanding about what mental health workers do, yes, it is a different pathway to nursing within acute trusts, different but unique with its challenges that many would struggle to comprehend. Mental health inpatient nurses look after the most acutely unwell people in the society many of whom have co-existing physical health problems making them particularly vulnerable. – P1 23/04/2019
>
> If a patient was mentally poorly enough to warrant transfer to an acute hospital, it will be these staff caring for these mental health patients in inpatient mental health hospitals. Remember these patients are brought in hospital because it is not safe for them to be at home so they have a vital role to play in keeping people safe. – P20 02/05/2019
>
> Patients detained in mental health hospitals and community homes were above 5,000 if I am right in 2018/19 erhmm … women, children, older people, secure services, LD (Learning Disability) services, mental health … we provide care to all of them. It is about time that we get recognised and people need to know the size and importance of mental health services. – P12 18/05/2019

In summary, mental health support workers feel that they are not recognised and are not given a voice. Their interview accounts appear to suggest that managers are not offering the support that they need and as such they feel belittled. This lack of voice means that they do not have control over their work and leads to a lack of understanding of what they do or who they are. This seems to be a significant cause of stress for people.

From literature, a lack of voice for employees and non-participation in decision making are widespread. If not acted on, this may have significant consequences for organisations (Martin et al. 2015). Despite all participants in this study having a shared caring nature, the perceived lack of recognition and involvement in making decisions within the team seemed to impact on them negatively.

5.4.3. Role and position in organisation

Interview findings from my research point out the role and duties of mental health support workers and support the claim by Wilberforce et al. (2017) that they carry out the duties of a qualified nurse:

> What is stressful now is the differences between roles for nursing assistants, nursing associates and even the qualified nurses. I find that sometimes that support workers carry out the duties of qualified nurses which is very conflicting. This causes severe stress as you are not sure what your job boundaries are anymore. – P13 21/10/2019

> Sometimes, we are now forced to do the jobs of registered nurses taking urine samples and analysing, assessing the needs of patients, making referrals to relevant agencies … and at the same time being in the forefront and spending time with the patients … this is indeed stressful. – P11 16/10/2019

> They didn't really know what to do with me or how to help me when I first started on the ward. There wasn't really a clear or specific role for me so it was quite confusing and conflicting. I didn't feel supported by manager either because she suggested to me to learn on the job and seek help from my colleagues. – P4 19/04/2019

My field notes on the lack of a clear role agreed with P4's comment:

> Some support workers commented that understanding of the support worker role across the Trust was somewhat limited. They think that even though there had been formal acknowledgement as to what their roles should look like at the start of their jobs, a few described feeling lost and unsupported as to the clarity of their roles when they started in their new roles. They suggested that this would have been due to none of their colleagues knowing what the purpose of a mental health support worker was on the ward thus leading to ambiguity. – Field diary 02/06/2019

While constant levels of patient contact do not necessarily set workers apart from those who are support staff and those who are registered nurses, the nature of the tasks described above depicts a distinctive role made up of complementary duties that should otherwise be performed by registered professionals. These tasks were often observed during my own shifts.

A registered nurse noted that it was difficult to see how support workers' role fitted into the existing nursing structure. She explained that it would be helpful if they were able to learn from the unclear and inconsistent way their roles have developed so that clarity can be established:

> I am keen to learn how our support worker role is structured because at the moment I think their roles are inconsistent and conflicting. it is important to get people to understand what the role is … It should be clearly outlined and explained from the beginning, so we know what the band 2s and 3s are doing to avoid confusion on the ward. – P35 20/10/2019

> The banding system is ridiculous it is unclear and confusing. I think all support workers have conflicting roles at the moment because they all want to work together but there are role demarcations, and this causes stress for them and for everybody. – P1 21/07/2019

The literature review argued that this lack of role clarity has led to some support workers feeling that they need to go the extra mile to prove what they can do and how they can demonstrate their level of expertise in their relevant clinical areas (Henshall et al. 2018). Henshall et al. (2018) suggested that this creates feelings of uncertainty for this group of workers, especially in terms of job security and career progression.

The interviews suggested that the mental health profession is extremely stressful with considerable pressure. Dealing with the role can be very difficult and little is known about the work involved:

> Dealing with the role as a mental health worker, the crippling anxiety that this brings is sometimes worse than mental health illness itself. The staff who are completely overwhelmed and bombarded with pressure and visions they can only "put in their box" are in desperate need of mental health resources which are scarcely available. It is an extremely stressful profession and yet little is known about them. – P30 28/05/2019

> Mental health workers save lives not just the general nurses. There is a lot going on about suicide awareness but without mental health workers there would be more suicides and other mental health problems like anxiety and breakdown. – P32 25/05/2019

> We are a bit hidden and forgotten about in the background as mental health workers. We are also keeping people alive every day some of us are now also moving to provide mental health support to NHS

> colleagues dealing with trauma working in acute areas and to the families and friends of people dealing with trauma when something unexpected has happened in their lives. – P23 05/05/2019

> Where do I start? As a mental health worker, we have many responsibilities, you are expected to give a holistic care erhmm … approach of care to patients. Holistic in this sense involves the main domains of both mental and psychological aspects of care. I take care of these patients as much as I can in terms of their mental health and yet we are barely even recognised. – P6 29/06/2019

In my experience as a support worker, I have been allocated on several occasions to general wards to care for a patient who was physically unwell and required medical attention alongside mental ill health. The nurses or nursing assistants often say they do not know what to do with patients who have mental health problems. Furthermore, if these patients become agitated or their mental health deteriorates, nurses or nursing assistants would not be able to manage the situation the way that mental health nurses and support workers do. This means that all healthcare workers are equally important although trained in different specialisms.

5.4.4. Allocation of work

Staff highlighted that they were sometimes asked to take on tasks outside of their job description, taking on more responsibility than they ought to be. This can be stressful:

> Support workers are not given any kind of control over their jobs because sometimes they are assigned jobs that is out of their job description and this leads to stress … we are not treated well, and we are totally disrespected by the registered staff and without us the NHS couldn't work as well as it does. – P15 26/04/2019

From my experience on the ward, I have been in a similar situation several times where I have had to carry out investigations that I wasn't trained for because they are not part of my duties, such as urine tests to check for drugs or urine infection. Tasks such as these are meant for qualified registered nurses, but I have had to learn on the job. My fellow colleagues are in a similar situation. I have seen some who now take blood from patients – a job meant for phlebotomists. Phlebotomists are allied professionals other than nurses and doctors who carry out phlebotomy: a process of making a puncture in a vein in the arm using a cannula for the purpose of drawing blood for investigations

such as medical testing. They belong to a professional body called the National Association of Phlebotomists. They are recognised professionals; this then raises the question of why mental health support workers who are not professionally trained are taking on such tasks. This seems to resonate with the theme of lack of recognition of mental health support workers within the wider NHS.

Another participant stated that support workers were often referred to as the unqualified, which to them is a dreadful term, and so did not have control over things that went on within the clinical area. This creates an atmosphere of unhappiness and can cause stress:

> It is very sad because very often support workers are commonly referred to as the unqualified on the ward who should not have control over any aspects of clinical care or on how and what kind of duties, they are supposed to take on the ward. It is a dreadful term and things becomes stressful because there is that atmosphere of unhappiness, because many support workers are well qualified not as a nurse but have plenty qualifications in other degrees and have very useful ideas. – P21 03/05/2019

The participants below shared this view. P1 felt he was not good enough in his job because of a lack of control, emphasising that the "big wheels do not turn without the cogs". In essence this means that even though they are seen as minor or low-level employees, their position within the organisation is important. Subsequently, P5, P20 and P22 expressed ill feelings of not being acknowledged and not having control in their roles:

> I am a support worker and proudly so and to be honest it just makes me feel as if I am not good enough because of a lack of control over the jobs I am allocated … erhmm … it's like because we are not registered nurses we don't count … I lack control in all aspects within my role and it doesn't seem to matter but we are all trained in our own right … the people at the top needs to be reminded that big wheels don't turn without the cogs. – P1 24/03/2019

> As a healthcare support worker, it hurts me when I see how clearly we lack control over certain situations on the ward for example implementing our ideas or following certain suggestions which we clearly know were made wrongly by the bosses … we are regarded as just the healthcare assistants, the NHS is one huge family from the moment a staff picks up the phone for help regarding a patient, they are immediately assessed and seen by the nurses or doctors and we attend to the patients as well

> so the cycle is endless but take a cog out of the team and it won't work. – P5 14/04/2019
>
> I would rate my stress threshold now say 10 out of 10. I work long hours and even stay longer some days when there is staff shortage, yet I am not valued and not recognised … The days are gone when the kind of support and expectations you get from the Trust was so … The good old days … – P20 02/05/2019
>
> Healthcare support workers are the backbone of the nursing community; they notice when a patient is very ill yet we have no control … many great nurses I have worked with even acknowledge this. They work so hard on the wards and support the registered nurses at all time so they should have some sort of control over their jobs and other important matters. – P22 04/05/2019

A registered nurse recognised the use and relevance of support workers in complementing each other in their roles:

> I couldn't do my job as a qualified nurse without my support workers … they are the eyes and ears of the registered nurses, and I am proud to call my support workers my dear friends and I would trust them with my life. The NHS would not be what is today without them. – P26 14/05/2019
>
> I think we have to do things by the book and that means that you don't have control over certain decisions and policies … you try to do something different, and they say it is restrictive practice … we are often guided by policies whether right or wrong. – P18 27/04/2019

In summary, one of the key conclusions derived from this section was the lack of professional recognition which participants saw as problematic. The findings suggest that mental health support workers believe that they are an unrecognised and undervalued group of healthcare workers in the NHS about whom little is known. They described themselves as being hidden and forgotten in the background without people recognising the important yet stressful nature of their job and their contribution to mentally ill patients in wider society.

The last section of this chapter will explore the organisational policies and procedures implemented by the Trust and their impact on workers.

5.5. Organisational Policies and Guidance

This section discusses the role and influences of policies as a stressor in the NHS. Clearly, from this study, as discussed in the previous sections, managers play a significant role in the design and implementation of policies. This can have a direct impact on the way stress is controlled and mitigated in the workplace. The procedure for implementing the sickness and absence policy is explained below by an admin manager participant:

> Initially, the conversation should be heard with their line manager as appropriate. The manager should get early referral fast tracked to team prevent. The manager should also do a stress risk assessment with them and best practice, though I wouldn't say it always happened, is that stress risk assessment is then given to team prevent prior to the referral process. The conversation happens with team prevent to determine what further course of action needs to be taken or what reasonable adjustments need to be put in place. So that might be whether you are going down the CBT with the counselling route signposting for a debt manager and all those kind of things and if it's to do with their workload or reasonable adjustments, all those kind of things, that would then be fed back to the manager and then it's the manager's responsibility to work through that for those reasonable adjustments in place, so that would be, you could get more complex things than that but I would say on a general day-to-day basis, that would be the route. – P34 10/06/2019

Employees facing stress will feel more aggrieved where they perceive inconsistency in the application of the policy from managers. This is a problem observed in this study: managers in the NHS tend to be inconsistent in their application of stress policy.

The next section will discuss the subthemes arising from policies and procedures.

5.5.1. Sickness policy and implementation

The sickness policy of the NHS and the way it is implemented provides a significant cause of stress amongst NHS staff, as found out in this study. The purpose of the sickness policy is to provide procedures by which staff can go on sickness absence leave. However, the policy is controversial and not completely acceptable to staff.

A manager was not even sure if the Trust had a policy around stress but indicated that the sickness absence policy was not liked by staff, and seems to be a major stressor:

> Have we got a policy around stress? I know that there is the sickness absence policy it is in there and it causes stress for the staff but I don't

> think it is a standalone policy, the sickness absence policy is not liked by staff at all, it was brought in on paper and as soon as it came in we saw difficulties and it took me 18 months of being a broken record telling everybody at every meeting that it wasn't working and it needs to be reviewed and staff were finding it punitive, we still don't think it's great. The Trust are looking at reviewing it as a whole. They want to look at calling it sickness and wellbeing again; however, something that I saw was that more people are calling it managing attendance rather than sickness, well it's more of a positive spin. The sickness absence policy in itself is not as bad as it is painted, it is designed to look at individual circumstances. I think the difficulty is that is then left to managers' discretion, some managers don't want to use their discretion, you might have two people one person who has a whole history of sickness, and you would make one decision about them and then somebody who is sick every 10 years or something and you would make another decision about them. Managers need to make decisions and stand by those decisions provided they can be challenged and justified. – P34 10/06/2019

The nature of the policy gives managers the discretion to implement it as they deem fit or suitable for each case. This gives managers the power to implement the policy flexibly rather than rigidly and at their own discretion. It means that managers in different wards can respond to sickness requests from staff differently and inconsistently. However, all sicknesses are still reported to HR through the sickness absence team, and at the end of the day, HR decides if the level of absences needs to be triggered and what actions need to be taken. Participants seemed dissatisfied regarding the nature of the policy and the way it was implemented, with managers not following it:

> The managers make the rules as they go along, not following policies and procedures, that's a massive issue with me. You have people being treated differently. I do manage up well though, I think I, I do (laughs) … – P10 08/05/2019

> Have you seen the rules and policies? I honestly do not bother to read them; how can we cope with all that? All it does is add stress upon stress for the likes of us who should be the one adhering to all that has been written up. Do people just make rules and expect you to follow them? – P6 14/04/2019

> I think the sickness policy is appalling. It creates stress at work because if you are poorly, erhmm you got stage 1, just going through that process, I think it's absolutely ridiculous, I think it puts a lot of pressure on people, erhmm, it makes people come to work when they are poorly. – P16 26/04/2019

> I am currently … I believe I am in stage 1, perhaps stage 2, all due to work issues and I, it's, I was off for longer than a year but it is the way it is, immediately into explorative meeting, straight into stage 1, monitoring periods for 12 months, can't go on the sick because that would trigger stage 2 but obviously mental health issues, things are not kind of good again at work, I am thinking perhaps am I going to go back on the sick if I go back to the community. – P26 14/05/2019

> I'm going to be in the stage 2 of sickness now and I stand the risk of losing my job, massive implications, and it's unfair. I think people's sickness should be looked at and if it is work related, I don't know … treat it differently and let the policy reflect this. – P25 10/05/2019

From the above responses, the sickness policy indeed presents a challenge for staff and causes stress. However, the argument from managers seems to be that the policy is fit for purpose, but that the implementation of the policy is the problem:

> We have had some hit from the sickness absence policy over time but it's not about the policy itself, it's about the implementation of the policy and the consistency of the implementation of the policy so I have in the past challenged and I would still challenge anybody that says the policy is not fit for purpose because actually I think it is, I think it's the way it is implemented that needs to be reviewed. – P31 27/05/2019

Even though the manager above thought the policy might have been working well, it is pertinent to note that he agreed with mental health support workers' views in relation to its implementation being reviewed. This view seems to be consistent among all participants. This is similar to the participant's account below. He agreed that there was nothing wrong with the policy itself but pointed out that the way it was interpreted and implemented was not consistent:

> There is nothing actually wrong with the policy, it's the interpretation and sometimes the implementation I think that doesn't always have a consistent approach … In terms of the managing sickness absence policy, erhmm it is quite difficult to corporate so if you are a line manager, it is pretty resource intensive to support an employee through that process so I think we can make improvements on that erhmm I think we can streamline the policy, I think we can rebrand, I think we can have more of health and wellbeing in the policy or framework as opposed to the sickness absence policy and flip that on its head erhmm all the tools are there in the box so we got stress risk assessments, stress at work policy, occupational health attendance management, I think we could make improvements. – P35 21/06/2019

This implies that if sickness continues to become long term, the trust policy becomes unsupportive and unfriendly in the eyes of staff as they would begin to climb the ladder of allowance available to them. If the allowance time is exceeded, staff may be suspended or sacked. It is the fear of this that causes many unfit staff to come to the workplace because they have exhausted their allowance. A manager said:

> I think from the short-term sickness is probably where staff are more anxious to being invited to the sickness meeting if they are going to be off eight days or if they had three separate occasions of eight days. As we know, it can only be three episodes of sick absence but when it has exceeded this you know what I mean, and it is eight days or less of each then this just causes some anxiety … – P8 14/04/2019

The implication of the above is that this particular NHS policy creates an anxious feeling amongst health staff who are genuinely sick and need to be off work for a longer period of time. The problem is that staying off work for more than three different episodes of sickness in a year, regardless of the number of days in each episode, triggers the punitive aspect of the policy. According to Boyaci et al. (2014), stress in the workplace amongst mental healthcare staff can be triggered by the kind of policies in place and the management style towards implementing such policies. Some who are genuinely ill are having to come to work to avoid being disciplined:

> If you don't come to work or you are absent more than three times you go on a level because there is a number of times you are allowed to be on sick for, after which you face disciplinary actions. So people are running from the levels and disciplinary action so they come to work with all sorts of infections. – P2 24/03/2019

The policy causes fear and anxiety amongst staff due to the contents and implications of its implementation. There is discontent about the policy and its punitive measures aimed at ensuring staff do not unnecessarily take sickness absence leave. The implication is that staff come into work unfit because they are trying to avoid being put on levels:

> Another issue again is about sickness of staff which I have made a complaint and sent emails several times complaining about the sickness policy of the Trust that it needs looking into to see if they can do something. Because the policy states that even when you are sick you have to come to work so some people have bacterial infection, they bring it to work and they spread it. – P11 09/05/2019

The implication above also is that the output or productivity from staff such as mental health support workers can be limited if they are unfit to work but have to come to work due to fear of facing disciplinary actions, losing their jobs or getting suspended.

5.5.2. Bereavement Policy

The aim of this policy is to support staff when they suffer the loss of someone close to them, including those who have someone close to them suffering from terminal illness. This is to ensure that care and compassion are provided to staff regardless of their grade or band, their length of service with the Trust and hours worked. Of course, the number of leave absences each staff member is entitled to will depend on their circumstances, and whether they are employed full time or part time. However, like sickness absences, each staff member is allowed a certain amount of time off work.

Generally, the policy states that people are entitled to a week of absence following the loss of a close relative or family member, but this could be extended further by days or a week depending on the level of distress and the circumstances of the staff member. This is down to the discretion of their line manager or an authorised manager.

However, according to the NHS bereavement policy (See Appendix XI), anyone classed as an employee is entitled to statutory bereavement or compassionate leave. This statutory right covers if their child is stillborn from 24 weeks of pregnancy or if their child dies before the age of 18; in this case, they will be entitled to two weeks of statutory paid leave. Also, if a dependant dies, for example their partner, parent or child or anyone reliant on them, they are entitled to statutory time off. In the interviews, participants discussed how this policy acts as a stressor because they are not given sufficient time to grieve for their loved ones:

> You find that a lot of people get their special leave for bereavement, two, three days, five days at best. It’s not enough to grieve and to get over the person that you have lost but then as I say, I got three days for my brother-in-law, I took a week and then half a week’s annual leave, came back to work for two weeks, I just couldn’t do it, I couldn’t manage, I ended up being off work for three months, the blame was because it was my wedding and all of that, I couldn’t deal with it all. – P5 14/04/2019

The way the bereavement policy is implemented is vital to how external stress accumulates with workers who are experiencing loss and grieving:

> To me the policy states for how many days, I think it's one week for close friends, family and few extra for whatever, but I was declined when I applied for more days leave to grieve but obviously it wasn't approved which is appalling because obviously the policy is there that says you are entitled to an *x* amount of days for the person, for a friend, myself … it is stressful not to be able to grieve and then return to work. I feel I should have been supported more. – P6 11/05/2019

> I was only given a day's leave to attend the funeral of a dear friend who passed away suddenly and outside of this I wasn't given any more days off which means I came back to work broken and carried on like that … I didn't feel supported at all, I feel it was fair to have been granted my request of a few more days away from work … it is called care and compassion. – P1 02/05/2019

The above quotes demonstrate that stressors originate from not being able to grieve properly and being forced back to work. People want to feel supported at work. However, the policy states that managers are to assess individual and personal circumstances and ascertain the number of leave days that may be granted. From my field diary below, I overheard a discussion among colleagues when a staff member lost their child and could not grieve as much as they wanted:

> It may be that staff and line managers should consider other options for leave in relation to bereavement for example utilising their annual leave if they have any hour left or requesting for unpaid leave if this will be granted by their managers. – Field diary 21/05/2019

In summary, this section has described people's feelings regarding the policies on sickness absence and bereavement and how these acts as sources of stress for them. The findings suggest that people come to work even when they are not fit, for fear of exceeding their allocated allowance off work which could lead to disciplinary issues. Hence, both mental health support workers and managers believe that the policy needs to be reviewed.

Also, inability to grieve properly due to the days allowed in the bereavement policy means that people do not feel they are supported enough through this period. Demonstrating compassion by managers means that people feel supported at work. Clearly, from discussions over the policies on sickness and absence, it appears that

people are afraid and worry about getting suspended, disciplined and even sacked if they exceed the number of days allowed.

Bereavement as a stressor in a person's home life, and how this spills over from home to the workplace, will be discussed in detail in Chapter 7.

The next section describes issues around disciplinary actions taken against staff and how these negatively affect their health and wellbeing.

5.5.3. Disciplinary issues

The participant below felt that there was bias over disciplinary issues, where some were being punished innocently and others were allowed to go free even when found to be in the wrong:

> When it comes to disciplinary issues, they are biased, and they are not fair in their decision making. They let some go free claiming no substantial evidence when there are clearly signs pointing to the truth. In other cases, you are punished innocently for what you haven't done. This unfairness is massively stressful. – P28 22/05/2019

The excerpts below suggest that investigations take too long and thus impact on the health and wellbeing of staff:

> Disciplinary issues or grievances is a real cause of stress … investigations are going on so long which is impacting on the wellbeing of staff and ultimately there is no outcome and so staff becomes unwell. – P30 26/05/2019
>
> I think when things like internal pressures impact or disciplinary issues or grievances we need to have a fully robust system in place so that if somebody is lost to sickness due to that process, then ultimately we get them back quicker, investigations are going on so long which is impacting on the health and wellbeing of staff and ultimately there is no outcome after their case is being investigated and so the person becomes more unwell, so I think we need support mechanisms in place to be able to improve those types of timescales required to sort out any disciplinary issues and investigations. – P20 02/05/2019

From my field notes, a staff member said:

> I have been accused of sleeping at work and the Trust never supported me when I was called in for disciplinary action. I was not on observations of any kind when I was accused. I accused the managers of not doing correct investigations. I had just come from my break sitting in the lounge

> and the accuser said he thought for a minute I was sleeping even when it was a clear I wasn't sleeping from my account and the account of the accuser … but no support whatsoever was I given in this instance and all my shifts were cancelled instantly until all investigations were concluded. Two weeks of work was lost with no source of income only for the manager to come and say they found no case and to return back to work. – Field notes - 12/04/2019

5.5.4. Lack of flexible working

According to the guidance published by NHS Employers in 2019, providing flexible working conditions for NHS staff is key to addressing current and future staff shortages. From the interviews, participants had a strong desire for flexible working to be implemented as a lack of it causes build-ups of anxiety and stress:

> Not all staff are able to request flexible working from day one of employment. So there is already anxiety and stress building up … even though there seems to some sort of policy on flexible working it is not clear how works … I have asked for some sort of flexibility around my shift patterns but all I keep getting is that it can only be facilitated if there was enough staff. – P15 26/04/2019

> I think that the morale and motivation of staff would have greatly improved, and stress levels would have dropped considerably if we were allowed more input into our working patterns. – P1 24/03/2019

The participant below suggested that for the Trust to be able to recruit more staff, they needed to advertise jobs as suitable for flexible working:

> As support workers and for the majority of the nursing workforce, our job should be advertised as suitable for flexible working; in that case we would be able to recruit more employees and people will be willing to join and work for the NHS. – P29 25/05/2019

Like P29, P14 felt that the Trust would continue to struggle with recruitment if flexible working patterns were not implemented, suggesting that sickness absences would remain on the increase:

> The Trust is going to continue to struggle with recruitment and retention and sickness absences will continue to increase … we need some flexibility, and the flexible work should be implemented without hesitation if things are to get any better. – P14 26/04/2019

The main drivers for flexibility for people are to balance work and other commitments (Savickas et al. 2009) and have more control over their time (Barley and Kunda 2004). This is in relation to the quote below:

> I have had to leave my substantive to join the bank because I needed flexibility around my work and home commitments … I have only just gone through a messy divorce, and I needed that time to sort my head out and look after my kids whilst still working. – P1 24/03/2019

A few of the participants said they had flexible working arrangements in place due to childcare issues but felt they could have been better. They gave varying reasons why they wanted flexible working, including improved work-life balance and the ability to fit work around caring responsibilities:

> I requested for flexible working to be able to self-roster and choose days that fits in well with partner as we have kids. My manager was very co-operative … it took time, but it was eventually granted. So, I think there is some sort of flexible working arrangement in place. However, there are days were there are staff shortages, and I am asked to cover those shifts … I feel it could have been better because some of those days I struggle with childcare, and I suppose you know that it could be stressful and frustrating. – P12 18/05/2019

There were workers who felt they were unable to continue with their full-time roles due to study and had tried to negotiate part-time hours:

> I requested to go on part time as I was due to start a degree course. The amount of time it took management to implement this and put me on part time was unbelievable. At a time, I thought it wasn't going to be possible to go on flexible working … I was stressed by the situation and was considering resigning altogether to pursue my degree when the Trust finally honoured my request. – P10 08/05/2019

Participants also reported various barriers as to why it was difficult for their managers and indeed the Trust to facilitate flexible working. For example, staffing issues:

> I have been told on several occasions that due to increased clinical activities and service improvement, my request for flexible working will take a long time to be granted. It is blamed for staff shortages with little or no staff to cover shifts most of the time. I am now left with very stressful conditions because I have a lot of other commitments outside of work which is daunting for me. I think things would have been a bit easier for me if I was allowed to go part time. – P2 24/03/2019

A few participants seemed to think that there was no flexible working policy in place, and some blamed their line managers for being unsupportive. Emphasis was placed on giving staff the flexibility they needed to balance things; otherwise, when issues get compounded, stress becomes inevitable:

> I think we need to work more flexibly because I am very sure there is no flexible working policy in place, I think we need to be able to move with the times – the times have changed there is pressure here and there, so we need to give staff that more flexibility to be able to balance things out otherwise things get compounded and then stress become inevitable. When it comes to working flexibly, my manger is not supportive in that sense. – P20 02/05/2019

Participant 23 recognised that it was easier to work on the bank because of lack of flexibility and not being able to work when she wanted in her existing full-time position. She acknowledged that some staff would often complain if another member of staff was getting preferential treatment and they were not:

> For me it is the issue of having the freedom of working when I want to, I like having the flexibility of working the shifts I want if I want to go or take a day off, I take it off without having to go through a process. My shift pattern weren't fitting my schedule of things at the moment, because if I was given special treatment then the other person would have to complain and ask why that person getting special treatment is and I am not and I had family issues, etc. So I decided to stay on the bank and work when I want to – P23 05/05/2019

In summary, flexible working has various benefits for both staff and the organisation. The most common reason for staff wanting flexible working seemed to be caring responsibilities (see Chapter 7 for more detail). From the accounts also presented by participants, managers need to look at the way that they design the duty rotas, and the Trust should state flexible working options when advertising various nursing roles to aid recruitment and retention. This will help to draw on a larger pool of staff, improve diversity and reduce sickness absence.

5.6. Concluding Remarks

This chapter has highlighted the stressors originating from the organisation affecting mental health support workers. The research participants quoted in this chapter attributed feelings of stress to having to work in the context of change, innovation and

efficiency; resource constraints such as staff shortages; career developments such as planning and implementing training; and organisational policies such as the sickness absence policy and lack of flexible working. Despite all this, participants discussed having a shared commitment towards caring for their patients; however, it was sometimes difficult to continue to work due to these stressors. Organisational change and innovation can be helpful and beneficial. However, managers and decision makers should think about sources of work stress when developing new strategies, especially during periods of organisational change (HSE 2020). In this way, by taking a preventative approach, organisations will be in a position to mitigate or reduce the sources of workplace stress before they become an issue. It is therefore important for the organisation to communicate issues of change effectively and in a timely manner to its employees. Issues of funding need to be addressed in order to provide the resources needed for people to function effectively in the workplace.

Tackling stress from the organisational level, interventions should also include providing adequate staffing levels, providing a workplace environment conducive to both staff and patients and ensuring work demands are not counterproductive to employees' health. Other factors the organisation should consider when managing stress at work include engaging employees in decision making and promoting employee voice and recognition over what is done and how. This, for example, includes involving them in decision making and engagement in the workplace. This could be in the form of team meetings organised by managers to gather the input and views of this group of staff.

The next chapter will discuss stressors from the workplace domain through the voices of both managers and staff.

Chapter 6. Workplace domain

6.1 Introduction

This findings chapter builds on themes arising from the workplace domain which cause stress for NHS mental health support workers. Previous work experiences, primary motivations to work and how long participants had worked for the NHS had major impacts on the accounts provided. Also, the meanings, whether directly reported by participants or interpreted, were mostly those experienced by support workers and a few others by management and occupational health specialists. A wide range of experiences were reported, resulting in a variety of meanings, but there were clear themes that emerged. These were manager-staff relationships, workplace environment and allocation of work.

The chapter is divided into three sections: workplace environment, organisational culture and the wider policy context. Throughout this exploration, the role of management and the staff-management relationship are shown to exert considerable influence on the role value, satisfaction, fulfilment and future plans of mental health support workers. It appears that these are influenced by management's style of service delivery.

6.2. Workplace environment

The way stress is perceived can sometimes depend on both individual and environmental factors. Participants in this study suggested that stress can be brought on by the working environment in which staff are operating, such as the physical nature of the ward, the level of clinical activity on the ward, or the nature of the work. These will be discussed in turn.

Firstly, for some participants, the physical work environment was not deemed conducive for either patients or staff. They highlighted poor ventilation, poor lighting, and temperature. Also, some of the wards lacked space overall, while the layout of other wards was deemed to not be conducive for effective working. This was particularly noticeable in some young people's wards. Also, staff described the ward temperature as too cold during winter and too hot during summer. From my field notes, I have overheard staff saying that

They were concerned about some of the ward layout which they describe as complex. They emphasise that the layout of a ward directly affects the safety of the patient and in some cases some of the corridors are too narrow and can affect the efficiency of staff especially when they have to deal with an escalating situation in the corridor.
Colleagues have suggested that ward layouts should be designed for flexibility and offer choice for both nurses and patients. Also, they recommend that patients should be admitted in hospital accommodations that suit their care needs - 21/07/2019

This encapsulates what was expressed by two other participants:

There is usually not enough ventilation in some of the wards. I wish a ward like ours was much bigger and spacious and not enclosed. No air is coming in and you feel more tired every time, this adds to stress for staff. – P10 08/05/2019

The physical environment is not fit for purpose. Sometimes I ask myself if management are aware of the state of some wards and what really, they are doing to bring it up to standard. These can be potential triggers for patients and with staff having to deal with the result of this can be an added pressure and cause stress. – P5 14/04/2019

There were some participants who felt that the physical environment was satisfactory. However, they indicated that some physical improvements were required; for example, the lights were disruptive for the patients, especially at night-time:

I think the physical environment on my ward is fine, however, I think the lights erhmm … I don't know what I would do differently about them but at night it disrupts a lot of sleep patterns for the patients because it is very bright, and this doesn't help to promote sleep either. – P3 03/04/2019

While some participants felt the temperature of the ward environment was not consistent with the weather conditions, others felt that some parts of the wards needed to be renovated or structured differently to make them fit for purpose:

The issue for me is the temperature on the ward it is very cold during the winter or uncomfortably hot during the summer. There never seem to be that right temperature. I have had patients complain of the hearing system too hot even in the winter. Things like this add up to stress. – P9 13/07/2019

The physical environment is quite all right compared to the old part of the hospital there are few bits and pieces that should

> have been changed or that should have been placed differently or some of the rooms structured in a way that is suited for purpose because the building is not that old, and management should have seen those things and made it better. – P18 07/07/2019

A diary entry also demonstrates what the participants are referring to:

> Sometimes, on some of the wards I have been to on night shifts had poor lighting. Some of the lighting systems do not work properly on a night-time. The wards are designed in such a way that the lights are expected to be turned down during the night to promote sleep hygiene for the patients. Unfortunately, some of these lights do not work as planned and so the lights are left on which makes the environment on the ward too bright. Some patients find this distressing and keeps them awake and for some patients, not sleeping means they will begin to engage in disruptive activities as a means of letting their frustrations out. This keeps everybody on edge and the ward becomes unsettled. When this happens, this leads to assault on staff by patients 9 out of 10 times. – Field diary 21/05/2019

Another participant who worked in forensic services, which is a medium- to high-secure unit, cited that the seclusion room (a room most often used to de-escalate very challenging patient behaviour whilst ensuring the patient's safety until they are well enough to gain access to the ward) was not ideally placed and difficult to access:

> Well the one most important thing for our ward being forensic is the seclusion room and the corridor outside of it is very narrow … when you open the door to the seclusion room, it closes like three-quarters of the corridor which makes entry very difficult and is stressful, the seclusion area is a little bit too small especially the entrance which is very little, the seclusion room is also too close to the bedrooms so if we had a really disturbing and loud patient there, the noise wakes up patients on the ward and that can be challenging for patients. Thus, when the ward becomes unsettled, it becomes stressful for staff and the rate of sickness absence goes up. Another thing that is not really an issue but should have been done better is the little courtyard for the staff room because of the design error it is difficult to access it and it is just a waste of space. – P7 14/05/2019

In other words, the physical nature of the ward environment can have an influence on the nature of the ward. For example, when rooms are built too small or entry and exit

points are deemed as not ideal, it can impact negatively on both staff and patients. People want an environment that will be conducive to recovery, especially due to the sensitive nature of mental health patients, who can become easily disturbed by noise. Secondly, in the following excerpt, a participant stated that stress was most often caused by the work environment, making reference to the busy nature of the ward and also its physical nature in terms of being poorly ventilated with inadequate lighting:

> Stress most times can be due to the environment staff are in … we have lots of different types of environments erhmm where there is high levels of acuity … there is increased levels of clinical activity, and then you have the physical aspects of things for example the wards may be poorly ventilated or the lighting systems could be poor. I have seen this in most of the wards I have been to, and this leads to a considerable level of stress. – P17 26/05/2019

A participant stated:

> You know psychological stress doesn't stay for a long period of time but can be very detrimental and is dependent on your experience on the ward. Most of the time this is due to the state of the ward and the ward environment itself at the time. I think the nature of our ward environment needs improving … our ward feels congested sometimes, I think we need more air and more lighting … it is tidy and very clean. – P11 05/07/2019

However, there was one participant who explained that neither the Trust nor indeed management was to blame for the state of some of the wards. For example, in terms of lack of cleanliness, he indicated that patients were to blame for this. He acknowledged that the Trust was doing its best to ensure a clean and conducive environment. However, in agreement with most participants, he also noted that improvements on some of the wards were necessary in terms of space and lighting:

> You cannot blame the Trust or management for the state of some of the wards in our locality especially in terms of the cleanliness of the ward environment; the domestics are trying their best all day, but you see the patients not taking responsibility at all to ensure they clean up after themselves … it's really hard when it is like this … however in some other aspects like space and lightings, there could have been more improvements for example, some are too bright, some are not bright enough. – P15 26/04/2019

In summary, this section has discussed the impact of the ward environment in causing stress for both staff and patients. The state of cleanliness, tidiness, lighting and poor ventilation were identified as stressors deriving from the physical nature of the working environment. Furthermore, according to the participants, the nature of the physical environment and the ability of management to provide a conducive environment are crucial. A safe and calm environment with easy access helps to provide the best care and reduce staff sickness, meaning people are more able to support each other, feel positive, safe and less stressed and anxious. Also, hostility, increased clinical activity and an unsettled ward were linked to the working environment; these impacted on staff morale.

In the next section, I discuss the subthemes – discrimination, conflict among staff and challenging patient behaviour – that emerged from the ward environment.

6.2.1. Challenging patient behaviour

Other research participants focused their accounts on the general atmosphere on the ward, describing it as hostile and aggressive, especially when they had challenging patients newly admitted into the unit. Interviewees reported working regularly with patients who had highly complex mental health problems. The most obvious examples were reported by mental health support workers and included patients with histories of aggression or assault charges and those with enduring mental health issues such as psychosis, schizophrenia and learning disability.

> The working environment can be very challenging, and you feel this sense of hostility when you have very violent patients on the ward. This is especially common in our acute wards, and it can be frightening sometimes. – P12 18/05/2019

Such hostility and aggression were often reported in relation to instances when acutely unwell patients who found it difficult to manage their emotions were admitted.

From my experience on the wards, such patients with difficult mental health problems often put themselves and those around them at risk of being injured when they become aggressive. This causes high levels of stress for staff, with anecdotal evidence suggesting that direct experience of violence triggers sickness absence.

From my field diary, the most common behaviours among patients with such disorders include hallucinations (seeing or hearing things that don't exist), delusions and nihilistic thoughts and beliefs (false beliefs not based on reality). Such behaviours when exhibited can be very difficult and stressful for staff to manage, especially when they escalate to violence and aggression.

As some of the participants explained:

> I have seen patients with history of severe violence and aggression and one of them presented with personality disorder and psychosis, he had virtually attacked and assaulted most of the staff on the ward and they were severely physically injured. Some staff after recovering from their injuries developed post-traumatic stress as a result of the incidence causing us to lose them to sickness for a long time. – P10 08/05/2019

> There is high levels of violence and aggression in inpatient units and within those areas you do tend to see a higher level of sickness absence. – P16 26/05/2019

In addition to this, one support worker reported working with patients beyond the level of sickness that was officially deemed suitable for their kind of ward. In other words, they had to deal with patients who were supposed to be on other intensive care units. This was usually down to decisions made by bed management due to funding issues, as I recorded in my field diary in relation to a conversation between two members of staff that I overheard whilst on shift:

> We now have situations where patients on acute wards are being transferred to rehabilitation wards due to bed management wanting to free up some beds for patients needing hospital admission from the community. They know that admitting such patients will be beneficial to the Trust and due to meeting budget requirements, they take on patients even when there is no capacity to admit them at that time. – Field diary 12/04/2019

Participant 9 reported their encounter with complex patients who were wrongly placed in settings for which they were not suited. As a result, staff were getting assaulted regularly due to the risks they were exposed to from these patients. This was linked to reports of sickness absences:

> I have worked with some patients who have been fairly complex and have had high levels of risks attached and obviously as a low-secure unit we shouldn't have really been involved with such patients … ideally, they

> ought to be admitted in PICUs [Psychiatric Intensive Care Units]. Well, as a result of the nature of the patients, staff were getting assaulted on a regular basis and there have been a lot of sickness absences as a result. – P9 17/04/2019

The diary entry below records some of the reasons why patients were placed in settings not suited for them:

> From my observations at work over a long period of time, it is indeed true that very high risks patients are placed in settings where they shouldn't be. What I found out when I did ask questions why this was happening was that bed management sometimes struggles to get bed for these people when there is increased clinical activity across the Trust, they are left with no choice than to place them in any available bed within the Trust. Answers to my concerns raised were also linked to target driven nature of the modern NHS. Management confirms that this is ideally wrong practice but in a time such as now when the NHS is struggling with available funds, they echoed that it is difficult to meet up to standards. – Field Diary 04/06/2019

Participant 30 also described being subject to frequent assault by patients suffering from schizophrenia, a chronic brain disorder. She was seriously injured and unable to return to her role as a mental health support worker; she now works in the administrative department. One of the injuries mentioned was a fracture to her coccyx. She described the situation at the time as being traumatic, and it led to prolonged period of sickness absence:

> I used to nurse patients a lot, so yes, I was always assaulted by patients with schizophrenia, that's why I am in admin unit now. I was a nursing assistant which is the same as a mental health support worker. One of the patients assaulted me and fractured my coccyx. It was quite a lot of pain and eventually I had to have the coccyx removed. It was an extremely traumatic and stressful situation for me. As you would imagine I was off sick for a long time so yeah, I have been there, I have done it. – P30 (Admin team lead) 26/05/2019

Participant 12 also reported being assaulted by patients with personality disorder. Her view was that staff were not at work to get assaulted. However, she viewed it as part of the job:

> Every now and again you get assaulted … erhmm I work with patients with personality disorder, I think I know that nursing staff

> are not here to be assaulted … nobody is here to be abused or get assaulted, but I have kind of took it as part and package of the job where you work even though it causes me considerable amount of stress. I have also worked with people with severe mental health problems having challenging behaviours, learning disabilities, so kind of I just took as the person, the individual and not a great deal whatever so I accepted it. – P12 18/05/2019

Participant 17, on the other hand, also drew attention to the stressful nature of being assaulted at work, which caused her to take sick leave due to the injury she sustained from an assault. On returning to work, her attitude changed, leading to anxiety because she believed she could not do her job properly:

> I think at a point when I was assaulted, I actually hurt myself, I have had black eyes in the past off patients with history of aggression, but I actually hurt myself where I had to take quite a substantive amount of time out of work and going back to work, there was that anxiety there but that anxiety was there because I couldn't do my job properly because I was physically in pain and I suppose kind of, when we are doing we were doing restraints I couldn't do it properly because of the pain in my back so I had to take time off. – P17 26/04/2019

In summary, challenging patient behaviour has been identified as a cause of stress amongst mental health support workers. The key point arising from this subsection is the difficulties of working with aggressive patients, the risk of injury and trauma involved. However, it is clear that violence, aggression and assault appear to be unavoidable parts of being a mental health support worker. This means that management may never be able to remove this stressor due to the nature of the work. However, even though this is the case, people are feeling left and abandoned in such difficult situations.

The breadth of experiences highlighted by participants indicate that perhaps the way work is organised, in relation to wrong placement of patients on unsuitable wards, is having an effect on people because nobody should be assaulted as part of their job, and they should not be coming in to work dreading being assaulted. Thoughts on how this problem can be managed include management taking responsibility and doing things differently to reduce the risk of assaults, by ensuring patients are adequately placed on wards suitable for their presenting condition upon assessment by the nursing team. Also, staff should be able to call for help, and people who are

trained should be available to act as response teams in emergency situations to deal with challenging situations.

This study acknowledges that the problem of workload cuts across both management staff and non-clinical staff such as support workers. Basically, most stressors are caused by workload, as one manager stated:

> I suspect a lot of the answers you are going to get to do with stress is workload and I wish it was different but the impact of workload on staff in causing stress cannot be overemphasised. – P16 26/04/2019

The problem of workload also emanates from a shortage of staff, which itself is a stressor due to the pressure it puts on staff. Clinical managers often also carry out administrative management duties; this increases workload and makes it impossible to attend committedly to employee issues such as stress. Another participant stated:

> Almost all the cases of sickness I have had in the last three months have been work-related stress and they have been legitimate work-related stress … and I think it is due to workload … it is that fine line detail, that prolong concentration and the number of hours and days they work per week. – P10 08/05/2019

Managers stated that workload itself caused stress for them as well as the staff they managed. They often needed to help themselves because sometimes, they had to combine duties covering a wider range than they were supposed to:

> It can be quite stressful at times and a lot of that is to do with the volume of work and also the level of distress. We do get some patients who are quite heavily traumatised and they got an underlying vulnerability factor and they have never brought them to mental health services necessarily in the past but in addition to physical health problems can activate those so we do have some quite disordered patients so and sometimes, it's about that and sometimes it is about the processes and procedures that particularly get in the way. I would say the other thing that is probably a source of stress is how can I put it, the (long silence), the balance of work within the role, it should be particularly at my level, a lot more indirect work, it should be more group work, teaching and training and dealing with particularly difficult subsection of patients but unfortunately, I end up having to do a lot of work that should be done by other services because the services aren't there and that puts more pressure so I do far more clinical work that I should be doing at my level. So, it's the balance of work within the job and not allowing me to do the role that I should be doing and I end up doing the job that somebody who actually could be four grades or five grades below me should be doing. So, it is the pressures of really working currently in the NHS. – P35 21/06/2019

The above quote clearly demonstrates that managers within the trust have voluminous workloads which can affect their commitment to helping staff under them to manage stress effectively. Aside from this is the fact that stress amongst managers is not just triggered by workload but can also originate externally. For example:

> Apart from the excess workload and pressure that managers face, there are external stressors from outside the workplace that can negatively impact such as peer pressure and stress from personal life situations. – P31 21/06/2019

This quote is indicative that external pressures outside work can be significant stressors for managers; this can impact both managers and the staff they manage, leading to breakdown in relationships between them. This will be discussed in the next section alongside other subthemes from the concept of workplace misbehaviour. These include staff-to-staff conflict, staff-manager relationships and discrimination in the workplace.

6.3. Workplace misbehaviour

6.3.1. Staff-to-staff conflict

Some staff believed that there was conflict due to miscommunication and misunderstanding which if left unresolved could lead to serious consequences:

> Last week, I almost made a decision to go home halfway through my shift. I was protocoled from my ward to another ward. When I got on the ward, the way I was treated by colleagues over there was horrible … I didn't feel welcome by them and I wanted to just go immediately. You could feel the hostility from their side and their non-verbal cues signified I wasn't a part of the team. – P10 09/09/2019

> There are massive issues around staff behaviour towards one another … there is hostility, and it is surprising to see a failure from management who wilfully allow such to continue … people are stressed as a result of this, and it need to stop. – P31 01/10/2019

> We should learn to care and support each other rather than engage in conflict. Most of the time it is due to miscommunication or misunderstanding and if left unresolved can have severe consequences. – P11 02/03/2020

Like P10, other participants acknowledged that workplace conflict could be attributed to ineffective leadership and management. They suggested that if management viewed the culture of the NHS as a caring organisation, they should be able to deal with workplace bullying more effectively:

> I think that some managers celebrate these perpetrators of bullying, misconduct and appalling behaviour among staff. Sometimes the stressors are not coming from patients but from colleagues … sadly it has been over 10 years I have been with the NHS and it is still ongoing. – P14 03/04/2020

> When it comes to workplace conflict and bullying, it is usually from my experience down to lack of effective leadership and support … managers and those in leadership positions can implement the right strategy if they understand the culture in the organisation … It is worrying to know that an organisation such as the NHS is still having to deal with issues of bullying when we are supposed to be a caring environment. We provide care and compassion to others but not to ourselves. – P32 09/09/2019

> There is sometimes negative behaviour from fellow staff creating a bullying culture of fear and intimidation. I find this really stressful, and it just wears you out because I think as colleagues it is extremely important that we should get along if we are to work as a team. – P23 10/11/2019

P20 suggested that the NHS needed to improve its workplace culture by eradicating bullying:

> The NHS needs to put in place a national body to improve workplace culture and eradicate workplace bullying among staff … there is so much conflict going on and the rate at which people go on sick as a result of staff attitude is appalling. – P20 05/08/2019

However, contrary to the views of many, one participant felt that from her experience, only a few staff members were responsible for conflict and the negative long-term effect it had on the organisation:

> From my experience, only a minority or I would say a handful of staff fight each other, however, the results of this behaviour can be long term and very damaging to fellow colleagues … you would like to think that we would have each other's back, but we pull each other down instead. – P21 03/05/2019

However, even though it might just be a few people behaving in this manner, going back to the idea of culture as previously discussed it appears that such behaviour is socially accepted and therefore likely to continue.

As discussed in Chapter 2 of this study, a working environment that harbours social tension amongst staff will trigger psychological stress amongst those who are at the wrong end of such tensions. This was evident in section 6.2 where the elements of the workplace environment were discussed. A participant noted:

> It is hard to put up with staff who is nasty to you for a 12-hour shift which is a long day. This causes psychological stress especially when you and the staff are on the same band 3 … what is the point in controlling other staff? It is useless and pointless, and I don't see the need for conflict. – P27 12/06/2019

The participant below felt that conflict resulted from power play regarding whose voice needed to be heard:

> Oftentimes, there is conflict among staff as a result of power play. You find out that one member of staff is wanting to exert authority over the other … there are conflicting ideas here and there and they fight over whose voice needs to be heard. This really makes this job harder when you find that you and your colleagues are not at peace with each other. – P26 14/05/2019

The participants below reported that even though staff were not at work to make friends, getting support from each other was important and conflict brought stress. One of them described support from fellow staff as being as important as that from management:

> Clearly, we are not here to make friends, but support from fellow colleagues is significant and goes a long way in determining how your shift goes for the day. In instances where you find that staff are not speaking with the same voice and are on different pages, it brings conflicts, and this further exacerbates stress levels. – P22 04/05/2019

> I never get support from colleagues; they are a pain … they start gossiping. When you are off sick not for one day will you find that your colleagues check on you to find out how you are doing … I think support from your fellow colleagues is as important as that from management. – P18 27/04/2019

Another cause of conflict was unfamiliar staff. A staff member who worked on the bank (workers who support the Trust's substantive workforce in caring for patients) acknowledged that being a bank worker was incredibly difficult because of the attitude of the regular staff on the ward:

> I find being on the bank extremely challenging because most wards you go to you find staff attitude and behaviour towards you appalling. They see an unfamiliar face and they are hostile towards you. One ward is particularly known for staff nastiness towards fellow staff but for confidentiality reasons I am not going to mention the name … you might know the ward [laughs] … as you work on the bank yourself. I mean the job is hard enough and to get such treatment from your colleagues makes it 10 times harder. – P12 09/09/2019

In summary, the findings indicate that workplace conflict could be attributed to poor leadership and management's lack of understanding of organisational culture. Those in positions of authority regarded as "management" are also part of the organisational culture, through their behaviours and the actions they tolerate or not. People want support from their superiors and colleagues, and individual behaviour towards one another is important. Developing a positive and supportive team relationship among staff, where they are able to discuss workload and pressures by finding ways to support each other and provide potential solutions, can reduce pressures and workplace stressors. The findings also revealed staff-staff dynamics in addition to a "them and us" divide between managers and staff. This will be discussed in the next subsection.

6.3.2. Manager-staff relationships

This section will consider aspects of the manager-staff relationship that research participants suggested caused them stress. They referred to a tendency among managers to blame staff for mistakes and abandon staff when they needed support. This, in turn, was regarded as causing fear among staff in terms of losing their jobs:

> If there is an incidence on the ward, those in higher authority will be looking for someone to blame for mistakes, they are not there to back you up and you will be left thinking if you are going to lose your job. This is extremely stressful for people. – P11 21/08/2019
>
> As a support worker, you are never right, the NHS will always find one reason or the other for when there is a problem, and this puts you in constant fear and you are at the edge of your seat all the time. – P20 20/06/2019

Another manager argued that compared to years ago, there is much more pressure on managers. This makes it difficult for them to get to know their staff and thus hinders an open communication between them and their staff:

> I think part of the difficulty in managing stress is that there is pressure on managers, 20 years ago managers will know every member of staff and all their kids and their aunties and their uncles and what was going on in their life but now all that has gone … there was that open and honest communication and I think it is that relationship between manager and staff isn't as it used to be so it's not so easy and people see it as a weakness to say that I am stressed. – P33 12/06/2019

In response to the quote above, it appears that managers face stress themselves and may be victims of stress-related issues as well. This may have an effect on their relationships with staff. It also means that communication with staff may not be as effective as they would like.

Another participant argued that you cannot have unhappy people looking after patients suffering from mental ill health, and it would be good to have somebody speak with staff for when they become stressed:

> It would have been good to have somebody to liaise with staff and make them feel like somebody because lack of effective communication causes stress for staff; that is somebody to specifically deal with staff issues, I can't promise the heaven but make sure people do their jobs well equipped to help the patients because this reduces stress. You can't have people who are not happy to look after patients who have problems you need to make sure your staff are happy with the environment and the working conditions in order for them to give the best they can. That is one thing that is lacking, the management is lacking from those on the floor. – P18 24/06/2019

At the start of this chapter there was a palpable "them and us" divide highlighted in some quotes and interpretations (P26; P31).

However, from the quote above, the message is that managers and frontline staff have to work together and that managers need input from their staff to understand what is happening on the ward in order to inform their decisions. in addition, according to literature, it is important for managers to understand themselves, and where possible, they should reflect on how they can become effective managers who are able to manage people, not only at different levels but within different organisational contexts (Martin and Siebert 2016).

Establishing the worker-manager relationship between these different groups of staff appeared difficult in the current study, inviting questions around the capacity of workers to raise concerns. Perhaps, as an earlier quote has suggested, this was due to workload. Managers do not operate in an ideal world; they have very high workloads themselves, they are victims of stress themselves and may be firefighting rather than doing the work that they feel is important.

Like the participant above, P8 suggested that managers should be encouraged to try and work things through with staff. But if this does not work then it may be necessary to go down the occupational health route to discuss options that are available and make referral where necessary:

> Well, erhmm I would expect the manager to sit down with them in a confidential space and try to work through things and talk together before it becomes full-blown stress and if they can work through it great and that helps to reduce stress … but if they feel that they need additional support, I would expect them to be in touch with someone in my team (HR) to discuss what the options might be and that could be referring to team prevent, it might be just changing their duties slightly erhmm it might be looking at the hours that they work. I think sometimes the Occupational Health element is great and would encourage staff to absolutely go down that route if somebody needed some support but sometimes managers wait for that a little bit which is fine because but there is certain things within your gift as a manager. – P8 14/07/2019

> Information is very important – some people don't get told what is going on in the ward which contributes to incidence and leads to stress. – P22 30/09/2019

Some participants reported feeling worried even after finishing their shifts and going home, hoping that they had done everything right for that day:

> Every time I finish my shift, I go home worried thinking and hoping I have dotted the Is and crossed the Ts, you are constantly evaluating and re-evaluating your decisions for fear of getting wrong … it never ends, you don't want to end up losing everything that you have worked for, it is scary. – P18 20/06/2019

> In terms of the risks involved with the nature of our job, you have to constantly think if you are doing it right or wrong. And then again, the fear of doing it wrong and getting suspended and even sacked is also a contributing factor for stress. – P25 19/07/2019

Two qualified nurses who were further interviewed stated that they were afraid of losing their NMC (Nursing and Midwifery Council) PIN (Personal Identification Number) due to making inadvertent mistakes:

> I am a newly qualified nurse and I constantly panic over simple mistakes and I often get anxious thinking that I might be losing my job or worse still my licence … Sometimes, because we are understaffed, I feel I am basically providing less effective care based on the fact that we are mostly being overworked, I then say to myself this is not the kind of nurse that I want to be, but the truth is I don't have a choice. I just constantly worry, and I am afraid all the time for fear of losing my licence/PIN. – P35 20/10/2019

> As a nurse, there are more and more paperwork being added to your workload all the time and there are new processes emerging every day. Once you see your boss walking down the corridor, you are left to worry and panic for a moment thinking they are coming for you or a fellow colleague. It causes anxiety. – P14 21/10/2019

These nurses were working in an environment where mistakes were prone to happen due to staffing levels and overwork, and they feared getting the blame. These quotes indicate that research participants were unsure if they were following and doing "the right thing", or if they might be in trouble for an innocent mistake. Such reports may be the result of the abolition of some regulations, as discussed in Chapter 5; this may lead to stress, anxiety, and fear of losing one's job after being blamed for a mistake. Indeed, some participants made a clear link between fear of losing their jobs and people leaving their jobs voluntarily for fear of getting unfairly blamed for mistakes happening on the ward:

> If there is an incidence happened on here, these will be looking for somebody to blame and when they find it they will put you in loads of trouble and the people who are boss won't do nothing about it and they will not back you up. – P4 16/06/2019

A similar sentiment was recorded in my field diary:

> Sometimes, colleagues face the risk of being dismissed from the workplace. I have seen people called in for investigation countless times and this makes staff panic a lot. Since the Trust is scared of the media, every little mistake is investigated, and your job is on the line. – Field notes 02/06/2019

My diary also captures an account provided by a mental health support worker:

> I was on a shift on my ward and the night co-ordinator rang and protocoled me to another ward for a swap with a male staff because the other ward needed a female member of staff. I accepted to go but told the night coordinator I would cover for a few hours and return to my ward due to risks the patient on that ward presented with. I was immediately told that it is either I stay on that ward for the whole night, or I go home and face disciplinary action on Monday. I wasn't given a chance to explain, and I felt threatened by being disciplined or possibly sacked. My rights were taken away from me and I was put under pressure to work on a ward which I didn't feel comfortable working on. My feelings weren't taken into consideration rather the night coordinator made me scared, threatened and bullied me into submission. I cried for most of the night and rang in sick with stress the following day. – Diary entry 06/08/2019

Regardless of support workers' role and position within the care team, their work is predominantly made up of patient-focused tasks that mostly take place on a one-to-one basis, and at other times under the supervision of a qualified mental health nurse. But participants felt they were not being looked after if something went wrong and felt undervalued by the organisation:

> The NHS does not look after their staff; a lot of the frontline staff are passionate about their patients and that's why they are still in the job to be honest … otherwise, someone like me would have been long gone. – P21 18/06/2019

Yet, importantly, there is recognition in the Trust about the complex dynamics underpinning such sentiments. For example, a member of the HR team suggested during the research interview:

> I think some staff what is their perception and a huge stressor is actually when you get to the nitty gritty of it is a small thing that can be easily rectified but if it being compounded by a number of other things then it becomes a problem so I think rolling out some managers' how to cope training will help managers have this conversation with staff so we can all take personal responsibility for our own stress and I think the resilience training will be rolled out further. – P28 21/08/2019

This HR professional recognised that apparently small issues can lead to significant stress for people who feel threatened by direct experiences or indirect reports of being unfairly blamed for mistakes and/or abandoned by their manager in difficult situations. Moreover, there is implicit recognition that not all managers may have the right skills or training to deal effectively with such situations. However, responsibility

for dealing with stress is shifted from the organisation to individual staff through reference to resilience training. As described previously, this is an area that participants had highlighted as lacking support.

Also, the data from this study indicate that poor communication can be a stressor for those on the frontline. At the same time, it can also be an issue for managers who do not have the time to communicate effectively:

> I think sometimes, the work demands exceed the number of people within the team to meet the demands all of the time and this this leads to pressure and affects the way mangers relate with their staff. – P34 29/06/2019

However, the quote below by P13, a mental health support worker, provides an idealistic impression of "good" management. As a mental health worker, myself, I would agree with this person's response that in an ideal world this is how staff should be supported through stressful situations. I would, however, argue that managers do not operate in an ideal environment. As discussed previously, the points participants raised about staff-manager relationships are crucial here, because nobody will be willing to speak to someone they do not know about stress:

> Well, if I was a manager, I would make sure I create proper awareness to staff, give them that privilege to open up, speak out whenever they feel stressed. When they feel stressed, it might not necessarily be work stress, patients or staff; it could be family or financial stress anything triggers stress in an employee and once an employee is stressed, he/she doesn't perform to the highest capacity, they don't function properly. I would encourage them to seek help regardless of the cause of stress early, try to speak to me as a manager or if am not there, any other person they feel comfortable speaking to. I will make myself easily reachable, even give them my phone number and be open and should be free to call me at any time and talk to me at any time concerning anything they feel worried about. – P13 26/04/2019

P13 suggested that it was important to give staff the opportunity to open up and speak, especially when they started experiencing stress. This would encourage them to seek help early. Perceived support is reflective of what kind of support would or should be provided that can be seen to address workplace stress (as discussed in this chapter), home-based stress (see Chapter 7) or a combination of both stresses:

> I thought I was going to be supported after returning to work as a HCA having been in a dark place last year. But all I have heard about since I

> returned is the amount of sick leave taken in the last four years and that I need not to be sick. I have a son with SEN [Special Education Needs] who can be a handful and I have had mental health problems due to his needs. – P19 30/04/2019

In summary, the importance of establishing healthy relationships is evident from the interview quotes provided above. It can be inferred that research participants would like to have more opportunities to discuss their concerns with their managers before they become full-blown stress. However, from the interview excerpts, it seems that although support is available for managers and staff, neither group feels sufficiently supported.

6.3.3. Discrimination

One of the themes identified from the data analysis was discrimination against mental health support workers by managers on grounds of their ethnicity. The findings from this study indicate that some workers from ethnic minorities experienced stress at work due to discriminatory practices and unfair treatment by managers:

> I have been treated differently by manager on several occasion, I often find out that I am not giving the same treatment with others who are whites. Unfortunately, I am the only ethnic minority staff on my ward. I am looked down upon and belittled … I ask for things which are not granted to me but clearly granted to others … I find that I am often scrutinised, and I am now afraid of making errors. Management feel I am not competent enough even with my years of experience … I term this unfair treatment. – P25 -10/05/2019

> I often find that I am treated very differently from my other colleagues in the workplace. It is most times very obvious and clearly my manager is always not fair in her decisions that are in my best interest. Severally I have asked for some development trainings that is supposed to aid my progression and several times she has either ignored my requests or promise to put me in for it. And then a few weeks later my colleagues who are English have been allocated the trainings … it is so frustrating, and I feel stressed most of the time. I am having to start looking for a job somewhere else because I am not sure I can put up with this as long as this manager is still here. – P29 25/05/2019

> I am not getting the job role I deserve because of my ethnicity. I went for an interview, and it was given to a preceptor, someone that has far less experience than myself. It was clearly a racial act … I can say that the person given the job has an advantage of me because of her ethnicity

> because it was obvious. The question here is if I was a white person who clearly had more experience than she had, would I not have been given that job? I sent emails for feedback to know why I didn't get the job and there has been no response till date. I have been to their office and left a message yet no response. – P18 27/04/2019

The above quotes above are similar to my field note entry during my observations at work:

> Staff felt they are discriminated against and not given training opportunities. These are extra training courses which should be available to staff if requested. These include phlebotomy, physical health, and family therapy. Minority staff members believe their white colleagues receive such training. Another member of staff stated that she and a white colleague went for an interview for a higher role. Her colleague got the job even though it was clear that she was less experienced. She believed this to be white supremacy and thinks that if you were white then you get prioritised for the job. – Field diary 08/05/2019

The quotes above express instances in which participants reported feeling treated as second-class staff. Three facets of discrimination were highlighted. Firstly, people felt that managers' and colleagues' reactions to abuse by patients were not appropriate. Secondly, people felt they were treated unjustly and unfairly by managers and fellow colleagues. Thirdly, staff from ethnic minorities felt that career progression opportunities were not made easily accessible to them compared to their white colleagues.

A participant's account was similar to my field note above. He stated that he tended not to speak up about discriminatory behaviours he was facing because of fear of what might happen:

> I tend not to speak up because I am worried about what the outcome would be. It is done without any evidence, and it is their words against yours. The more you speak about something the more you are punished. For example, allocation of observation, black minority staff get allocated more hours than their white counterparts. They use policy to justify what they are doing so it is pointless speaking up. – P20 02/05/2019

> They try to cover up by using policies, procedures and clinical judgement to cover their racial act, but they know exactly what they are doing. – P14 26/04/2019

These excerpts suggest that the participants considered discrimination to be embedded in the organisation to the extent that policies would be used to allegedly justify such behaviours. There was an unwillingness among minority staff to engage with managers because they reported feeling that nothing would be done, and they would not receive support:

> I don't feel like talking to my manager because as a minority I don't think I will get any support. I always feel as a minority because no actions will be taken, and it is just a waste of time really. I would rather personally deal with it. – P2 24/03/2019
>
> Managers can belittle you in front of your colleagues making you look like a fool you know my health and wellbeing is suffering as a result … I will never report it in my supervision because I know that nothing is going to be done anyway. It does cause me stress and most times I go off sick with stress. Then when I am back at work I just ignore them because the more you think about it the more you don't want to continue with the job. – P13 21/04/2019
>
> I have struggled and battled with being treated differently as a result of my ethnic origin. I have seen patients being verbally aggressive towards me and calling discriminatory names. Staff have been witnesses to this on many occasions and they either pretend they haven't seen or heard the patients or make comments like well … he is a patient … this has caused me considerable stress; I am anxious about going to work all the time and I don't feel like any staff member is bothered really about how I feel. – P24 10/05/2019

Similar to the quotes above, the following excerpt from my field diary was recorded following a conversation between me and a member of staff during one of my shifts. It suggests that some people prefer not to speak up about incidences of discrimination because they feel nothing will be done about them:

> A staff member said he remembered when he was an agency staff and on one of his night duties, the night coordinator who was passing by as he sat on observations made a comment that this was not the kind of job meant for people like him rather, he was better suited is a bin collector. He said he never reported the incidence because he felt nothing would be done about it. Eventually, few months down the line, she made a similar comment to another ethnic minority staff who reported to top management and that was when he also spoke up and she eventually got suspended and faced disciplinary issues. – Field diary 08/05/2019

One participant described feeling stressed because she felt excluded by her manager because she was black. She described situations where colleagues questioned her competency on the grounds of her skin colour:

> At the moment I am experiencing very high levels of stress and I am very emotional. I feel left out of the group sometimes … I question the issue of inclusion by manager … it is a shame that an organisation such as the NHS still discriminate against their ethnic minority staff. I have overheard fellow colleague saying that blacks are not competent enough and lack intelligence and when I did confront this staff, she stated that our level of reasoning was not the same as theirs and that she had facts to back up her statement. Things like this make me not want to come to work after all. – P8 14/04/2019

Another participant confirmed the above, suggesting that minority groups are not considered or involved in decision making due to the colour of their skin:

> I am not involved because sometimes they look at you and treat you according to your background … Your colour, your skin, because they think who is he? As a brown person or a black person you are not supposed to speak when we are speaking … so even if your ideas are very good they will throw it under the carpet or try to make it look as though it's their own idea even when the idea has clearly come from you knowing your idea could have worked better but because it came from you, they would not want to go through with it – I am usually stressed by situations like this and I start to wonder what the use of our yearly trainings on diversity and equality really is. We go for this training but yet it is not being practised. It is stressful and oftentimes I would rather remain on the sick. – P1 24/03/2019

Some minority staff members provided examples of stress emanating from discrimination – being different due to the colour of their skin:

> Being that I am minority I sometimes get racially discriminated against I must have to be honest with you, but you just have to deal with it in your own little way sometimes you get other staff members reassuring you, but it is what it is … Yes, it is sometimes stressful to be different as a result of the colour of your skin or your ethnic background. When I get stressed, I ask for help and support from friends and families and not from management because I will never get the support. – P18 27/04/2019

> Management is aware of what is going on and they are not bothered about it. Managers have been reported to bully people especially people of colour. They discriminate against you in an institutional manner. They

> speak of equality and diversity when indeed there is no equality and diversity. – P21 03/05/2019

The field diary below was an observation at work during one of my shifts:

> A staff began to question herself if she was good enough in her job or not because of her colour and because of the perceptions of others that English language wasn't her first language. I also observed ethnic minority staff discussing the fact that when protocoled they get sent to busy wards whilst their white colleagues get sent to a low stimulus ward. They feel they are always picked on and refer to themselves as "those meant to do the dirty job" and reported feeling stressed as a result of this. Staff in this instance indicated that racial discrimination particularly when combined with ethnicity had a strong influence on work-related stress. – Field diary 10/07/2019

A participant in his interview stated:

> I have witnessed a lot, there was a time I witnessed a patient passing away in hospital and the way my manager handled the situation was unfair. You could clearly perceive discrimination and favouritism. We were three of us that went to hospital to support the patient and sadly he died that night. When we came back, they only picked one staff and asked if she was OK and sent her home while two of us were left on the ward to carry on with our duties for the night … clearly, we all needed a debrief and I didn't get one; I felt I was treated differently. I was clearly traumatised and devastated due to the events of the night. This led to stress for me, and I had to be absent from for a few weeks. It is not the first time things have happened wherein I was treated differently. – P13 10/10/2019.

The support worker was explaining that after witnessing an emotionally distressing situation which involved the death of a patient, the support provided by the manager was unequal, suggesting favouritism towards a particular member of staff from an English background. He felt that because he was from a minority background, his manager did not consider giving him the same level of support he provided to the other member of staff. This staff member expressed how he would have wanted the situation to be addressed:

> What I expect from a manager first of all like the incidence I reported earlier, I would have wanted my manger to call the three of us that witnessed that incidence and would have liked a debrief, then after which they can suggest I take a day or two to have some time away to grieve and reflect on what happened away from the environment. It would be up to me to decide if I wanted to take the time off or if I was able to cope with the

> situation by still coming to work … that would have been my choice to make. If I then choose to remain at work and carry on, I expect to get a call the next day asking if I am OK and coping because people's stress level is different. Some people can handle stress better than others … however, witnessing a patient passing away impacts on the staff mentally and it is often a difficult and stressful time. – P13 21/08/2019

In interviews, some staff members explained that they were experiencing open racism and how that made them feel. Participant 11 noted unfair treatment while participant 12 noted that other staff members witnessed this and did not take any action. Acknowledging the mandatory training offered by the Trust regarding equality, she commented:

> The racism I experience is in an open form. I have been spoke to by colleagues who have made derogatory remarks about me. It makes me feel sick, belittled and hopeless sometimes. The annoying part is that people who witness things like this do nothing about it, rather they support it. No matter the trainings we attend on equality and diversity, nothing much seems to be changing. – P12 18/05/2019

> There is open discrimination against most people from black background. There is inequality and unfair treatment. Ethnic minority people get failed from their nursing degree without justifiable reason and even without any action plans in place to support them to pass and progress with their careers". – P11 09/05/2019

However, one staff member was of a contrary opinion, highlighting that racism was not shown openly but rather hidden. Instead, management would give reasons for why things are the way they are:

> I would say it is a hidden kind of discrimination the type that it is hard to prove or there is no evidence to prove that you are being discriminated against. They would never say you are being denied such and such because of your colour. They will give reasons which really doesn't make sense … this has negatively impacted my health and wellbeing for a long time now. My coping mechanism is seeking support from families and friends. – P33 06/06/2019

In summary, this section has explored the subthemes which emerged from the workplace environment. The findings suggest that inequalities and discrimination in the workplace related to ethnicity can be a source of stress in the workplace. Issues of inequalities and discrimination appear to reflect wider cultural issues in the organisation. In some work situations, people of particular ethnic origins are treated

less favourably than others, for example through unfair treatment and lack of support. These factors can act as a source of stress both for the individual and the team.

The interview excerpts and some of my field diary notes further suggest that discriminatory behaviours appear to be tolerated in the Trust, despite attempts to ensure a fair and inclusive work environment, for example by providing training on equality and diversity. These reported experiences may hint at a wider culture in which discriminatory behaviour is largely tolerated; this would explain why the training on equality and diversity is deemed to have little effect in practice.

6.3.4. Ethos of care/lack of support

The NHS is an organisation whose job is to care for people, some of whom are very ill. As such, it might be expected to have a culture in which staff are also cared for and supported. However, this is not the way in which my research participants described their lived experience of working in the Trust. Participants described the NHS as inconsiderate and referred to themselves as being just numbers:

> You are just a number working for the NHS they don't give a sh** and there is always someone else to take your place. – P7 14/04/2019
>
> The Trust doesn't care about how you feel all they say is just go on and get the job done … Get on with the job that is all they tell you … As long as the documentations are all up to date that is what matters. The bosses they don't care about the staff. – P25 10/05/2019

Participant 4 below described support workers as replaceable mushrooms who are fed a diet of liquid manure. This means that they are kept in the dark and fed dirt:

> The NHS is not considerate; we are just numbers, and no one cares. We are replaceable mushrooms kept in a dark place and fed a diet of liquid manure. We are just a number no empathy or help when we need it. – P4 03/04/2019

The excerpts below state that the NHS is supposed to be a caring profession, but staff are not cared for or supported the way they should be, which causes stress for them:

> Unfortunately, when it comes to the NHS where its staff are concerned it is not all honey and roses as people would expect. Yes, we choose to be in the profession, but we are not always treated and supported in the manner that we should be treated, and this is stressful, we are supposed to be a caring profession … – P10 08/05/2019

> A caring profession which is not very good at looking after their own staff. Feeling appreciated and supported should have been automatic but sadly it doesn't happen. The lack of support and understanding has been shocking especially when it is within your own teams. – P15 26/04/2019

Another worker who had been with the NHS for 38 years agreed that the organisation lacks support for its staff, and that without support stress may be difficult to manage and sickness absences may become inevitable:

> I have been a support worker since 1983 and it is a shame that in all my years of service, I perceive that we get no support at all. In any healthcare care or medical field, it is essential that no matter your status we should be provided with the support that is needed especially as we claim to be a caring organisation in that way stress will be managed and sickness absences may drop … we are healthcare workers. – P27 16/05/2019

It appears that participant 18 shared the same view; as a result of lack of support, she was often on the sick because her mental health was now affected:

> I am suffering from anxiety I have worked for the NHS for 39 years it is hard working with patients who have got PD [Personality Disorder], dementia and Alzheimer's in an impatient ward. It is extremely stressful without support and has now affected my mental health; I am 60 years old and off most of the time with anxiety and depression. Horrible times. – P18 27/04/2019

A lack of support can have a significant impact on stress amongst mental health support workers. Support is not just restricted to management; it also includes support from peers. This significantly triggers the psychological aspect of stress:

> In terms of physical stress there is not much but psychologically, there is a lot of stress and this has to do with one's mental health and wellbeing which is important. On the ward, you are not just assigned tasks to do certain things but in terms of the job itself, and in terms of the risks involved with the nature of our job, you have to constantly think if you are doing it right or wrong. And then again, the fear of doing it wrong and getting suspended and even sacked is also a contributing factor for stress. Because of the consciousness of the job, and the risks involved on the job, you need to constantly think if you are doing this right and if you are not doing it right. Again, even with fellow staff not being supportive, instead of encouraging and supporting you, they are thinking of how to get you in trouble, constantly looking for faults here and there,

> the thoughts of these alone while on the ward is stressful and this is psychological stress. – P13 21/07/2019
>
> I think there could be potentially more support around the psychological interventions and for those to be offered quite quickly, so I think that could be improved but in general … – P33 06/06/2019
>
> It boils my blood how very often we are treated and not supported just because support workers don't have degrees doesn't mean that they are anything less! Support workers are the backbone for nurses, and it doesn't matter what title you have … no one is any better just because they have a degree on a piece of paper. Light blue or dark blue it doesn't matter what colour of uniform you are wearing everyone is part of a team and no one should feel anything less. – P12 18/05/2019

Some participants pointed out that the NHS only cares for the patients and not the staff. Some described the caring profession as a laughable description while others described the NHS as an organisation with so much game playing:

> I feel in the NHS you are not just a number, but they don't actually see you as a person with feelings and emotions. It is almost as if you are not allowed to be human and just need to act like a machine. The caring profession is a laughable description, caring towards patients and their families not the staff. – P14 26/04/2019
>
> As much as I am loyal to the NHS, there is so much game playing and unnecessary unkindness and lack of support, I will never understand. It is sadly not the caring profession towards its staff. – P21 03/05/2019
>
> I have come across some kind of behaviour towards NHS staff it is as though all of the compassion is directed to patients only and staff get very little. A colleague of mine developed PTSD [Post Traumatic Stress Disorder] and their lack of understanding led to her going off on long-term sickness with a complete breakdown. – P3 03/04/2019
>
> This is the NHS for us … we are in the caring profession but if we the staff are the ones that needs caring for then they can't even give that care and support back. Needless to say no compassion, we are supposed to work for a "caring company" but it is now – a "business" sadly. – P4 03/04/2019
>
> It is an organisation that cares more about the patients, and they are banging on documentations being kept up to date … anything at all that has to do with their performance is all they care about in case they appear before the court of law. There is no care or support for the staff. – P11 09/05/2019

In the excerpt below, the NHS is referred to as a business and the pressures on staff to live up to expectation seem to be paramount, rather than caring and supporting them:

> It is not about the staff or the awareness of the staff, it is about the business, everything is about the business now because that is what the NHS has turned into … a business … are we doing up to the expectations of those giving us the money to run this business? That is the question they care about … there is nothing much about personal development or support for the staff that looks after the patients. – P25 10/05/2019

The participants below blamed management for the lack of support. They indicated that strategies employed by management were not the best and they would expect an open-door policy from managers:

> The way some managers treat us is really sad, no support at all, I would expect an open-door policy … I observe that they talk more to doctors and nurses and then we are neglected … we all put our necks on the line as a duty of care so I would expect to be supported fully when needed. – P19 30/04/2019

> Management strategies are not the best and I have had bad experiences as usual, and managers are not interested in you the person no more this is what I have sadly found out after 47 years in the NHS that you are just a number. The only important thing I always remember is that all the patients that you have cared for over the years will remember and respect you for what you are – a caring and valued nurse. – P23 05/05/2019

However, a participant from HR indicated that staff were encouraged to share their concerns and seek support if needed, with supervisions offered monthly and health and wellbeing initiated. That said, she was not sure if all these resources and information were actually having any impact as there were still high levels of stress being reported:

> I think they are encouraged to share their concerns and seek support and I think through their supervision, through their support network, I do supervision and as part of that we have interviews, how can we support you, what is going on with you, is there anything that we need to be aware of, and supervision happens monthly, erhmm it can happen more regularly if that individual requires it erhmm so it is actively encouraged, it is actively discussed. The health and wellbeing initiatives are promoted erhmm it is kind of like ingrained, in terms of opportunity, we don't actually know the impact of that yet so if we have all these campaigns

> and we have all these information and we give it all out, we don't actually know, the health and wellbeing team will know the uptake and maybe work with the information that is there, the uptake, the involvement and the actual impact and how that makes the difference, I don't know if we know that. So all the resource and information is there but what is it doing? Because there is still stress, there is still physical issues and I think that will always happen but at the minute I don't know if we are measuring that correctly. – P30 26/05/2019

Another member of the HR team made some points that were consistent with the above. She acknowledged that there were various forms of support available even for members of staff who were unable to share their concerns with their direct managers, including an escalation process. However, like the previous participant, she was not sure if these support mechanisms were being utilised by staff or if they were indeed working as expected:

> I think there are regular structures for staff to be supported … if you talk about the localities they have a team meeting, they have their supervisions and we do have speakeasy events, we do have staff events and we do have corporate events more widely. Also, we have speak-up guardians, we have staff-side representatives and there is the employee who have their line manager, if they are unable to talk to their line manager, there is a change of command and escalation process and ultimately you have got ourselves (HR) and staff side (UNION) who are impartial in their field so I think support is quite accessible yea. The question remains are they making use of these? – P33 06/06/2019

In the excerpt below, an HR manager was unsure how much support staff were getting, regardless of the various support mechanisms made available by the Trust. He pointed out that there was mixed feedback around occupational health not providing clear information and sometimes managers complained about contradictory information which made it hard for them to tell if staff were getting enough support or not:

> We do support employees … yes there is referral to team prevent, they are signposted to the care that they need individually, and we listen and talk to the employee to understand how best we can support them … so there is a health and wellbeing contract review which happens on a quarterly basis so we are able to feed into that in relation to staff experience with occupational health that's all fed back to us and we go into the contract review to talk about it so there is that opportunity to give feedback, receive feedback and talk about what next. However, there is mixed feedback so we get feedback around occupational health not providing the correct information, for information that's necessarily not understood or clear we hear managers say it is quite contradictory they don't answer the questions but also you have to think of the referral, so

> was the referral clear, what did you ask and sometimes we do have to go back and forth to ascertain the facts but we are told our outcome is only as good as our input erhmm so therefore, it is pretty hard to answer. There is positive and negative feedback. – P31 27/05/2019

From the excerpts above, it seems there was no consistent standpoint to perceived support, with varying responses to availability of support from the HR team. HR staff suggested that support was available for those experiencing stress and that there were support systems available for any staff needing support. Conversely, support workers expressed a lack of support from the Trust and management. The next statement was provided by a manager:

> Yeah, I think that the support is available for staff and I think it is about accessing that support, you know, it's a challenging financial times at the moment and I think everybody is feeling that pressure and so we more than ever kind of be able to work in a team to make sure that patients get the best care. – P35 21/06/2019

The problem, though, is even if this support is available, the effectiveness and timeliness of the process are important. Unfortunately, findings from interviews below indicate that even after referral to the counselling team, the process of attending to staff can be time consuming:

> I was referred for counselling, I am still sitting waiting for counselling and that's like seven to eight months down the line it takes a long time to sit and wait, when I actually needed it then I probably still do need it now … it's sit and wait really … – P8 14/04/2019

> For a manager who only works part time and a staff report being sick on a Tuesday for example, the manager may be absent Tuesday, Wednesday, and Thursday and may not report till Friday. They have missed three days where there could have been a referral and be offered support needed and sometimes it is longer if that manager is on annual leave. So you are left with no support whatsoever. – P12 18/05/2019

What this means is that there is no robust process in place where somebody else should be taking over that referral, so if the manager is on annual leave when somebody is off poorly, it could take up to two weeks to get them referred and provided with adequate support. In terms of having more physical contact with the patients, support workers expressed that they were more involved more than other members of the nursing team.

> Support workers have way more physical activities in respect to patient care than doctors and nurses on the ward, hence they should be supported but there is obviously a lack of support from management … we have time to support the patients, do the observations, BMs (blood sugar monitoring), incontinence, all personal care including bagging up laundry both wet and soiled. – P17 26/04/2019

> I think there should be changes to the way we are supported as support workers … where would the NHS be without the hard work of support workers? We/they do most of the "hands on care" for patients like washing, feeding, personal care, turns to avoid pressure sores … I really think we are undervalued. – P20 02/05/2019

Managers themselves can become stressors for mental health support workers because of the perceived lack of support these workers get from their managers. As support workers perceive the attitude of managers as unhelpful with their stress or challenges, they become more stressed when they are able to forecast and predict the responses they will receive:

> I told management and it's not a threat that I feel if I go back to community it will massively impact on my wellbeing and I will end up being on the sick again due to stress because I know that if I go back to where I was, I am going to be sat under the manager that I clearly got issues with … she is unhelpful and doesn't support me … her attitude is a disgrace and is stressful working with her. – P1 24/03/2019

> Well, my current manager is fantastic, previous manager was shocking, absolutely shocking. She is not a manager; she shouldn't be a manager. She is not very good at all, erhmm I think if it is not her immediate staff, well if it is still her immediate staff, she doesn't respond. She just doesn't deal with it. That is where I kind of ended up having my issues with her. I became very stressed myself because I wasn't being supported to support my staff. – P2 24/03/2019

> My first manager was good and always listens and provided ad hoc supervisions, but he changed, and people started complaining that there was not enough support. He was being criticised for not giving critical feedback, but he would crucify you for what you didn't do right; people were lost to sickness and agency staff had to be used for most of the time. – P5 14/04/2019

A situation like above when not managed effectively can degenerate into stress, with staff going off sick because of poor support. The implication of this for the NHS is the possible rise in costs involved in covering shifts using agency staff in place of regular members of staff who are absent as a result of sickness.

However, one manager in her interview suggested that managers should create more time to support staff even in the midst of varied demands:

> I think obviously, to be able to provide more time I suppose to ensure managers support staff if that makes sense because sometimes with the varied demands, I suppose there is an expectation of managers whereas sometimes you might need that little bit more support with sort of managing some of the people side of things. – P6 14/04/2019
>
> I think that mental health support workers are not supported at all unlike doctors, nurses and healthcare assistants on the general side of nursing … we do a lot of work and yet don't get any recognition … we are a forgotten role yet doing all the important work. – P4 03/04/2019
>
> It is so sad, we are the backbone of the service, remove the bottom of the pyramid and the whole lot collapses … remember that … – P11 09/05/2019
>
> It is atrocious … everyone is important and deserves to be supported from domestics to consultants and should all be treated equally and shame on the managers who don't support us. – P29 25/05/2019
>
> We are often called just the support workers because I felt as a band 2 I was not given enough support and not deemed important enough … or maybe it is because we are not registered it is sad but it is true that support workers are all qualified in their job role. – P11 09/05/2019

The above excerpts suggest that support workers do not feel supported and sometimes experience low status in their career position. Likewise, the participant below also showed signs of frustration at her status:

> Whether nurses or healthcare support workers you are not only looking after the poorly and sometimes very ill patients but are also helping to understand why their lives have been impacted on negatively and these are some of the most vulnerable people you can think of … I just think we are the unsung heroes and without us the NHS will come to a standstill. We deserve all the support that we can possibly get. –P19 30/04/2019

I shared this support worker's frustration at not being supported, especially when the job role is looking after very vulnerable people. This can be very emotionally draining, and to not get the support you need makes things even worse.

> I don't feel supported by the Trust when there are incidences on the ward or on your shift, they say they offer debrief to support you and I think that's about all the support you can get. – P21 03/05/2019

> I wish I could say I am fine but I am not … at 53 years of age, I thought it would get easier in terms of the support I was getting but it is not and I have always loved my job and given my best but now I am feeling as though I am being fed to the tigers. – P7 14/04/2019

> It is sometimes extremely difficult to switch off from work as a support worker because you see and feel a lot and the heavy burden of this can often lead to stress and a sleepless night. More so, this can be exacerbated when you feel unsupported by management. – P2 24/03/2019

The quote by P2 indicates perceived difficulty in switching from work when at home, which can lead to stressful situations. This suggests that stress does not exist in an isolated or specific domain of people's lives.

In summary, this section suggests that there is a lack of support from managers. Support mechanisms implemented by the Trust may not be working as expected. Managers are encouraged to create more to support time even in the midst of varied demands.

6.4. Concluding Remarks

This second results chapter has discussed the management issues causing stress for mental health support workers. The key themes that emerged from discussions provide an indication of the meaning individuals attach to stressors associated with the workplace domain. This contributes to existing literature by extending the understanding of what working in the NHS means to the participants. Significant findings suggest that the ward environment and the perceived level of support available had a negative impact on both staff and patients.

Some of the main challenges appear to have been a lack of involvement in decision making and not feeling valued. These themes were generally reported far more negatively than I had expected. However, a small number of positive accounts by participants allowed an examination of key influences on workplace support. From this standpoint, three factors emerged: discrimination in the workplace, conflict amongst staff and challenging patient behaviour. These factors provide opportunities for the NHS to address stress if managers are able and willing to devise strategies for

addressing them (Holmgren 2016). However, some employees expect that stress at work should be managed effectively by managers as this would also contribute towards a positive work environment where staff can flourish.

The findings also suggest that factors such as exclusion from the team, lack of support, unfair treatment and issues of career progression as a result of race may reflect the wider cultural issues of discrimination and inequality. For example, some of the interview excerpts suggest that staff from particular ethnic origins are treated less favourably than others. These factors can act as a source of stress for some people.

However, it was encouraging to see the example where a staff member spoke up and their line manager was penalised for discriminatory actions. This indicates that the Trust is taking action against such behaviour. It therefore seems a shame that few research participants reported discriminatory behaviours to their line managers. Where there are people not speaking up when they feel treated unfairly or in a discriminatory manner, there is little management can do to signal that such behaviours are inappropriate and therefore not tolerated in the NHS. As such it is unlikely that the cultural acceptance of racist and discriminatory behaviour will change. All these issues demonstrate clear links between discrimination and stress as highlighted by research participants.

The last section explored the ethos of care and lack of support. The findings indicate that most of the participants who were mental health support workers did not feel that they were cared for or adequately supported by their line manager or the Trust. However, managers tend to think that there is support available for anyone who needs it. The problem, though, is that even if this support is available, the effectiveness and timeliness of the process are important. Unfortunately, findings from my ethnographic field notes indicate that even after referral to the counselling team, the process of attending to staff can be time consuming.

As the quote by the HR professional implies, the NHS is not an uncaring organisation as suggested by some research participants. However, a myriad of issues, pressures, and stressors contribute to feelings of stress among staff in the organisational context discussed in Chapter 5.

Finally, the findings suggest that not all stressors are work based as there are influences from outside of work that could be triggers of stress. People go home and

are unable to switch off from work. This spill-over from work to home and the interface between home and work will be discussed in the next chapter.

Chapter 7 – Home domain

7.1. Introduction

This chapter explores the life domain, comprising of a discussion of the themes of bereavement, relationships and caring, mental health, poor pay and the nature of work. Sometimes, people may suffer from stress that is not work related but rather caused by external events originating from their personal lives that are difficult to avoid. Stress in a person's life domain can spill over into the work domain and reduce people's ability to cope with stress at work. It is here that feelings of lacking support or being abandoned, as discussed in Chapters 5 and 6, can exacerbate experiences of stress.

It may be difficult for people to differentiate stressful experiences in their personal lives from those experienced at work (Leka et al. 2016). Findings throughout this chapter suggest that work-life balance is a theme that feeds through different aspects of people's lives. However, where a perceived optimal balance was achieved, it resulted in such a close integration between work and life that hours spent working were no longer measured, as the boundary between work and life became almost indistinguishable. This may be due to the fact that people are experiencing excessive pressure and demands in the workplace as well as outside of work. This means that stressors at home can affect those at work and vice versa. Some participants did not want to engage any more with the traditional pattern of work; this appeared to be mainly due to perceived organisational constraints (see Chapter 5) preventing balance between work and life

7.2. Nature of work

This study suggests that work plays an important role in the daily lives of workers, especially healthcare staff who have little or no time for their personal lives after working long hours. Working long and tiring shifts means that people do not have work-life balance, which can cause stress.

> I work 12-hour shifts four times a week and, on my days, off, I tend to catch up with other things which I haven't had the time to do while I was at work. It is difficult and stressful I just feel I do not have a personal life at all and I have personal stresses as well and work sometimes spill over to home. – P12 14/07/2019

It is important to consider mental health support workers when it comes to this dynamic because the results from interviews indicate that the nature of their job can be quite demanding. Below is an excerpt from my field notes:

> On one of my conversations with a colleague, she expressed that she has found it difficult to switch from work even when she is at home and on her days off because she is worried about not dotting the Is and crossing the Ts. As such, she is constantly stressed and for her she finds it difficult to distinguish which stressors affects her the most whether those from home or from the workplace. – Field notes 06/08/2019

Also, from Chapter 5, participants wanted flexible working so that they could reconcile work and caring responsibilities to avoid a build-up of stress and pressure (see Section 5.4.3). Where flexible working was not facilitated by management, some participants reported feeling "emotionally" overloaded, and having difficulties maintaining an effective boundary between work and home life:

> I am completely overloaded emotionally at the moment; I find it hard to switch off from work even when I am at home … I think it is compassion fatigue and this creates difficulties for me maintaining effective boundaries between work and home life. This is causing me significant levels of stress … it is just hard. – P17 06/05/2019

This means that stress from the home domain can result in emotional overload, spill-over of work into the non-work domain and difficulties with boundary management. As discussed in Section 5.2.2., a participant's account was similar to the quote above; they reported that inability to balance home and work commitments was one of the reasons why the Trust might be finding it hard to retain staff.

One of the participants reported working with patients having complex needs, especially those in acute mental health wards and the Psychiatry Intensive Care Unit (PICU). Support workers in this instance were required to manage issues surrounding complex patient-worker relationships, including maintaining boundaries and potential dependency; for example, making healthy choices, assertiveness, and creating physical and emotional space from intrusion.

This has led to issues such as being unable to switch off at the end of the working day. This is an element that can be conceptualised as another boundary between home life and work life:

> We are being asked to manage complex patient-worker relationship for patients who are acutely unwell … this is a Psychiatric Intensive Unit and it is comprised of many complex and unwell people it is difficult to build a relationship with these set of patients and it is stressful and it is hard to switch off at the end of your shift which means it spills into home for me and the stress just carries on. – P15 13/06/2019

This quote is similar to one in Section 6.4.3., where the participant discussed how he was unable to switch off from work when at home due to the nature of the job. P10 reported that working as a support worker in a mental health unit was draining compared to other jobs. He stated that it was hard to go home and not worry about your patients, which made things difficult:

> Working as a support worker is draining it is not like a normal job where people can go to their 9–5 jobs and then shut down the computer and go home without actually not thinking about your clients for the day … whereas in this job, sometimes you have left behind patients who are feeling suicidal and self-harming … you learn how to cope but I don't think I will ever be able not to take issues at work home with me even though you are trained not to … I go home to my family and sit worrying and stressed out thereby making things at home difficult. – P10 11/08/2019

The quote indicates that the nature of the job as a mental health support worker makes it harder to "switch off" from work even when they are at home. P9 and P20 describe home stress as being very difficult such that it makes people unable to tolerate the extra stress from work. This demonstrates clearly that there is spill-over from home to work and vice versa. P20 further discussed how because of his shift pattern, he was unable to address the issues from home in relation to his recent divorce from his partner of 20 years:

> It is almost like the home stress gets people to a level that they just cannot tolerate that extra stress at work. – P9 17/04/2019

> The stress from home makes it even harder for me to accommodate the stress from work. My shift pattern is not fitting my schedule of things with regards to issues from home. I spoke to my manager regarding this, but the issue is my manager was concerned that if I was given preferential treatment for this then the other staff would complain as to why they are not getting the same treatment. So, I made a decision to go on the bank and give up my substantive post because the stress from both sides became overwhelming. – P20 02/05/2019

P20's response suggests that managers believe granting flexible working to some people can be perceived as preferential treatment by colleagues and this can be difficult to manage. As such, people are giving up their substantive permanent posts to become a bank temporary worker with a zero-hours contract. People are also thinking of going part time because they feel that there is no reprieve from work, which is depriving them of spending enough time with family:

> I am thinking seriously of going part time at the end of the year because what I want is to have time for my family … I am supposed to be on annual leave but I am right here sat at the front of the computer still working … I mean I love my role and the job but it is not giving me enough time for the family and this is causing me stress. – P13 21/04/2019

My field notes below support P9 and P20's view of the inability to accommodate stress from home and stress from work. The excerpt refers to an instance when I overheard staff discussing how difficult it was balancing work and home issues:

> It becomes annoying and difficult when you struggle to balance issues from work and home. There are times when people have had to call in sick because there was just no other way out, basically it just becomes too much and just wouldn't cope any more. – Field diary 12/04/2019

An HR professional noted in his interview that stress from home for some people reaches a level where they can no longer tolerate the extra pressure from work:

> It is almost like the home stress gets people to a level that they just cannot tolerate that extra stress at work, it is not necessarily the work stress that is a bulk of the stress that people report … I would say that is probably the case for most staff. – P31 27/05/2019

Another HR professional reiterated that in most cases, members of staff have identified the stress they were experiencing as work related, but in actual fact, it is usually home stressors:

> A wide range and the majority of cases that I have had, have all identified their cases as work stress, however when we actually meet with these people, 95% of cases is either related to home stressors and one thing at work has tipped them over the edge but they have identified it as work-related stress. – P32 22/05/2019

P28 and P29, also members of the HR team, emphasised that some people have very complex home lives that can impact their tolerance to pressure at work. They noted that this could be due to personal reasons, with people suffering a lot more now:

> Sometimes the daily grind of home and work is normal you know how we help people cope with what is normal erhmm and the normal fluctuations of life and that's why there is a lot about resilience to help there. – P7 17/04/2019
>
> It would be a range of reasons, it can be personal problems, you have a lot of staff who have very complex home lives and that is impacting on their resilience and their stress. – P28 22/05/2019

In agreement with the comments above, from my diary, I observed staff discussing this among themselves:

> Stress can result from personal problems which can cause a lot of suffering. There are a lot of staff who have very complex home lives, and this is impacting on their resilience. – Field diary 08/05/2019

This was confirmed by another member of the HR team:

> Sometimes we assume that people are off with stress resulting from the workplace but what we find when we have dug into people who have been off with stress is that lots of them have extremely complex home lives so we find that there is an element of work that we can sort out by for example changing their rotas and workload but other times, it is the flexibility around the home life that people need as well. – P34 10/06/2019

It appears that like P34 and P16 acknowledged that people had identified their stresses as work related when in fact, they were either caused by home stressors or one thing at work had tipped them over the edge:

> The majority of cases that I have had, they have identified it as work stress, however when we actually meet with them 95% is either home stressors and one thing at work has tipped them over the edge but they have identified it as work-related stress so actually for us that is a positive because we can put loads of resilience plans in place to help support the home life we look at flexible working, reducing the hours things like that to support their home life so work isn't becoming that added pressure and that is the tricky thing to do and I think I am quite fortunate in corporate we have got much more flexibility in corporate, it is in clinical areas that is where the struggle is so we have a lower rate of workplace stress for that reason I would say. – P16 04/04/2019

A support worker shared her experience of the impact of being unable to balance work and home life. She said that it affected her marriage and her children and acknowledged that she was going to pretend and carry on even though she was feeling stressed and struggling:

> Not being able to balance work and life issues has had a massive impact on me, in my relationship, in my marriage, affecting relationship with my children and even the people around me and in all of this I know I must still be going to work and pretend as though all is well but deep down I am struggling and feeling very stressed at the moment. – P19 30/04/2019

An HR professional in charge of implementing and amending Trust policies stated that there were pressures as well as personal issues impacting on people. This in turn made work-life balance difficult, especially when there were targets to meet. During the interview, they commented on external and internal pressures impacting on staff:

> There is pressure, work-life balance is difficult, I think we have got external political pressures and then we have got internal working pressures and we have got our own personal issues all impacting. It feels a lot more pressurised now, there are targets all of the time to achieve. – P31 27/05/2019

In summary, flexible working and work-life balance are important to staff and when effectively managed can help to reduce stress, for example by offering alternative working hours/patterns, or part-time work. However, many research participants found it hard to balance work and life together, which could result in stress. Sometimes, it was assumed that people were off with stress emanating from the workplace, but it was sometimes as a result of stress outside of work which could be for various reasons including complex home lives.

As such, managers should consider how they approach requests for flexible working and/or how to address work-life ba6ance issues. However, according to one of the interview excerpts, some managers believe that flexible working can be difficult to manage because it can sometimes lead to perceptions of unfairness when granted to some members of staff. If unaddressed, such behaviours can lead to increased levels of stress within the team and the organisation, despite being intended to reduce levels of stress.

7.2. Personal factors

Personal factors such as poor pay leading to financial difficulties, relationships and caring responsibilities, bereavement and mental ill health can conflict with demands from work.

7.2.1. Poor pay

Another theme identified as a stressor in the home domain of mental health support workers in the NHS was issues around poor pay. These findings are supported by a 2019 survey (Salary Finance) which found that nearly 40% of NHS employees across the UK were suffering from ongoing financial stress with serious implications for their engagement with work and their mental health. The report identified that NHS Trusts across England could save £2.3 billion yearly by introducing employee benefits, such as low-cost loans and salary-linked savings that would reduce the costs arising from poor work-life balance and stress-related absence.

P2, when asked during the interview what his stressors were now, replied:

> There is inadequate personal and monetary rewards for me … I worry a lot about finances, at the moment there is so much going on in my life in terms of money issues and it is really stressful for me … I sometimes go to work feeling excessively worn out and it is a result of the pressures from home not necessarily stress at work. – P2 24/03/2019

He referred to going to work feeling worn out, which he thought was as a result of financial difficulties in his private life rather than stress arising from work.

Similarly, participant P8 stated that financial problems were a significant external stressor for him and his family:

> At the moment I am having family issues around finance. I have been through a lot over the last year and accumulated a lot of debt which I am paying monthly by direct debit. My take-home pay at the end of the month is not enough to cover payments and this is causing me stress. So, I would class my stress levels to be due to issues from my life and not necessarily from work. P8 – 14/04/2019

The level of financial difficulties was so severe that even the union's effort to support staff was not enough. A member of the union noted that some members were experiencing financial difficulties which were leading to stress, and even though the union had a charitable welfare pot for people struggling financially, it was sometimes not enough:

> Some staff are suffering from financial difficulties which is causing them stress. If people are struggling financially, we have erhmm a welfare pot and an officer supports staff to fill in a form and it is an onerous form considering the amount of information that you have to provide. This will usually put some people off but payments are made based on needs and if staff members are in serious financial difficulties there is an emergency payment. However, this seem not to be enough, and staff are carrying on being stressed from this which oftentimes spill into the work environment. I always advise anybody struggling in that sense to contact the citizens advice bureau as they are good on benefits. – P26 (Unison) 14/05/2019

From my discussion with a staff member from the union, financial challenges are widespread in the trust. However, this problem is not limited to support workers; it also occurs with higher-band staff, as mentioned by the participant below. The degree of financial problems is relative; that is, the higher the pay bands, likely the higher the expenditure:

> I think it's gradually increasing. You know we do have staff who struggle to make ends meet. They are working additional hours to try and put food on the table for children, they are not getting that work-life balance. One of the things that I was really, really, really quite shocked at, I'm not going to mention any names but I was in the equality and diversity meeting and we had to explain to senior members of staff within this organisation that yes actually we do have band 6s who use food banks, because that person was under the impression that if you are earning that money you should be fine but what that person didn't realise in real terms is that we've all had a period where we still have to pay the bills, we still have to pay the mortgage. – P31 27/05/2019

In order to meet financial obligations such as mortgage payments, staff would usually work extra hours, thereby making it difficult to get the right work-life balance. Some higher-band staff in clinical lead positions even went to the extent of using food banks so as to reduce the financial pressure they experienced; this could happen at any set time in their lives. The relationship between financial problems, poor work-life balance

and stress was clearly identified in this study as staff continued to push themselves until breaking point:

> The house market is stagnant so if you need to downsize, you can't necessarily do that because you would lose too much money, negative equity, people are just being caught up and they are trapped and so they feel pressured into not going off sick, pushing themselves too far, doing extra shifts and to add to that, when they do go off sick with stress, they are absolutely petrified that they are going to get sanctioned when they return – P27 16/05/2019

The comment above suggests that stress is sometimes brought on as a result of staff pushing themselves beyond their limits, for example taking on extra shifts. This means staff sometimes do more than required so as to meet up with the financial demands of the moment, to the point that they feel too pressured and then go off sick due to financial pressure outside the workplace.

In summary, the findings from this theme suggest that financial challenges are widespread in the Trust. NHS workers face financial challenges and along with these come stress, which can sometimes spill into work. This can affect staff turnover and cause absenteeism. Just as funding challenges lead to resource constraints, thus affecting how staff do their jobs which can be stressful, so also personal financial difficulties due to poor pay impact on staff. Therefore, financial difficulties impact people and act as a source of stress, both from the organisational level and from the home level. However, this problem is not relegated to support workers; staff in higher roles are not exempt from this burden.

7.2.2. Relationships and caring

This study found that relationship breakdown caused stress amongst support workers. Severe emotional disturbances emanating from marital and relationship challenges were an external stressor. This evidence was presented by a participant:

> I think that I carry all the stresses from work to home and at the moment it is having a negative impact in my life, my marriage has broken down which is causing me more stress and my relationship with my children is affected. I then go to work with all these baggage and become even more stressed. I have spoken to manager who was kind enough to give me some annual leave which is the best she can offer. – P2 24/03/2019

There is clear evidence from this study that the stress of broken-down relationships can affect people's ability to concentrate and work effectively in the workplace. Also, the responsibilities of being single when a relationship breaks down increase stress levels because of the additional responsibilities of the single parent. This is illustrated in the comment below:

> My relationship with my partner broke down and as a result it was difficult to cope with family needs which involved taking the kids to school and then swimming lessons. I had to go on permanent night shifts just so I have the day to do all of these. But then the stress is too much for me I can hardly sleep during the day and then I go to work and there is work stress. But generally, it is the spill-over of the stress from home that is affecting me badly. – P1 24/03/2019

Relationship breakdowns create complexity in the lives of those affected. This leads to stress which affects the quality of work:

> There is definitely something around complex home lives definitely, so I think they tend to be things like relationship difficulties and that can be with a partner or actually with family. – P15 26/04/2019

In addition, findings suggest that work on its own can contribute to relationship breakdown:

> I think that the one reason why my relationship has broken down is because there wasn't any flexibility for me to balance my work with my personal life including pressure and stress from work. My partner wanted a 100% commitment form me and that I couldn't give because of the nature of my shift pattern. I was so stressed at the time because I was struggling to make my relationship work and at the same time trying to be sane at work … it wasn't an easy ride and I always knew that one was going to give in in place of the other and sadly I had to sacrifice my relationship. – P4 03/04/2019

Increased pressure and stress from work was seen to impact relationships. So did working long hours and spending time away from home, which participant 2 said he really struggled with at the time. These were contributing factors not only causing him stress but costing him his relationship.

Staff responsibilities towards caring for family members and the stress these caused was another theme found out in this study. Different levels of care such as

looking after elderly family members, children, and disabled relatives amongst others constituted an external care responsibility stressor confronting NHS staff. The participant below expressed in his comment that juggling between the home care front and the workplace was difficult:

> Home life, family life and stresses outside of the workplace are massively impacting so there is so much around caring responsibilities, parents juggling caring responsibilities with work … in fact that dynamic also, looking after elderly relatives sometimes could be daunting for staff. – P10 08/05/2019

The interesting thing to note from the comment above is that caring for the elderly at home can be very demanding and daunting, making it difficult for staff to cope with their job demands in the workplace. Participant 18 also noted that being unable to balance work and life commitments and missing out on family time as a result of the shift pattern was causing her stress and resulting in her calling in sick frequently:

> Finding that work-life balance is difficult for me, I am worried about childcare, missing out on family time when working long days with no support network around me. It is just me and my husband and I am stressed to say the least. I am having to call in sick every now and again which is not good for my records because there is only so much time you can be absent for. – P18 27/04/2019

From the quote, this participant was also worried about calling in sick all the time due to lack of childcare. As seen earlier in section 5.5.1., people found the sickness policy punitive because there were only a limited number of times a worker could call in sick, otherwise it would be triggered by HR, and this could have consequences for the member of staff involved.

From my diary, a member of staff was discussing issues around caring responsibilities for a child and getting on with work commitments:

> I just want a good quality of life for my daughter. I need to be able to spend more time with her and right now even though I am in a nice working environment with such a great team, I still feel stressed just by the mere fact that I have to work weekends sometimes and it is hard to be with my daughter who is only one. I feel like I am missing out on her life basically. I intend to go for a community job and work 9–5 Monday to Friday. In that case I have the weekend off and also have the evenings with my partner and daughter. It will make me feel less anxious and stressed. – Field diary 04/06/2019

The HR manager below, when relating the stress that people faced, stated that it could be that stress was starting as work-related and then contributing to other areas of the person's life, such as worries that came with caring for others:

> I think the other thing as well is health or caring responsibilities that people have and the stress and worry that comes with that. But I am not sure if the stress is starting with work-related stress that contributes to other areas of the person's life. – P33 (HR) 06/06/2019

> Home life, family life and stresses outside of the workplace are massively impacting so there is so much around caring responsibilities, parents juggling caring responsibilities with work … in fact that dynamic also, looking after elderly relatives sometimes could be daunting for staff. – P12 18/05/2019

Participant 12 noted that juggling between home life and the workplace was difficult; caring for the elderly at home can be very demanding and this might make it difficult for staff to cope with the demands of their jobs.

Similarly, from the excerpt below, coping with a full-time job and having to also be responsible for the home front is very challenging for staff, leading to some staff either going into part-time jobs or considering doing so. This again could have financial implications for staff, leading to more stress:

> Honestly, I am thinking of seriously going part time at the end of the year because I don't want to leave the profession altogether, I love for my role. However, I am struggling to balance work and the issues around my home at the moment, so it is causing me considerable amount of stress. What I want is to be able to have time for my family and I am supposed to be on annual leave, but I am still working from home. – P23 05/05/2019

From my field diary, a staff member said this to me on one of my night shifts:

> She has heard staff ring up and reporting being stressed from all the caring responsibilities from home for example being a carer to a disabled relative at home. – Field diary 04/08/2019

This challenge is even more difficult for single parents who have to cope with the demands of external care responsibilities in combination with work duties. For example, the participant below had the difficult responsibility of looking after a large

family and required extra support, which seemed to be lacking, making her situation even more stressful:

> I only just joined the Trust as a support worker, and I am a single mum of four … it is bloody hard work and the mum guilt is real. It would have been easier with a good support network to help with the kids. It is a sh** show for me, and I am full of stress not just from work but mostly because of this family issue but I am carrying on hoping it will get better. – P22 04/05/2019

This suggests that the support worker felt the pressure from home due to caring responsibilities and experiencing stress as a result of being a single mum. However, P10 suggested that home stress could be higher in women of a certain age due to life changes, expressing that these could impact the level of stress they might be experiencing:

> It seem to me that domestic stress was apparently higher in women of a certain age who may be going through life changes such as menopause, leaving home, erhmm relationship issues. – P10 08/05/2019

P14 and a HR manager also explained that even though a lot of people reported being stressed and were off work as a result, most of the time they were off due to caring responsibilities. They suggested that it would have been better if such cases were badged differently on the reporting system rather than being recorded as stress:

> So we have a lot of people who are off and it would say stress on the system but actually, they are caring for their erhmm their elderly mother or their child for instance, so something has happened to that person and so they need to look after them so I will just badge that differently. – P14 - 14/04/2019

From my diary, I observed staff usually citing caring responsibilities as one of the reasons why they were off work:

> They could suddenly get a phone call the morning of their shift from a close relative that a brother or a sister had just fallen ill overnight and needed to be taken to hospital, it leaves them no choice than to call in sick to work as no one else other than them might be available to care for that person. – Field diary 06/08/2019

This suggests that support workers are likely to take time off to deal with emergencies involving children, relatives and other dependants. This could lead to high rates of absenteeism or staff sickness.

7.2.3. Bereavement of loved ones

The empirical evidence from this study, some of which was discussed in Chapter 5, shows that bereavement can present significant levels of stress (see section 5.3.2.) which originate from outside work. Bereavement was described as a significant external stressor that research participants felt required more attention from the organisation. Participants did not feel like they had the right support when they suffered bereavement, and this contributed towards escalating their stress. The main issue was that the policy around bereavement appeared not to be supportive towards staff. This study found that the implementation of the bereavement policy by managers was not rigidly followed as a standard:

> The managers make the rules as they go along, not following policies and procedures, that's a massive issue with me. You have people being treated differently. – P13 21/04/2019

Some people thought that the Trust policy on bereavement did not give people enough time to grieve when they were bereaved, and this could add to their level of stress and hence lead to absences by calling in sick. The bereavement policy doesn't allow staff many days off to grieve for their loved ones. The policy (see Appendix XI) states that staff members who have been bereaved are entitled to up to one week (i.e. five working days) of compassionate leave for any full-time staff member on a 37.5-hours contract and pro rota entitlements for part-time contracted staff. However, in particularly distressing circumstances, an authorised manager, at their own discretion, can consider extending this by another week of paid or unpaid leave. This is seen in the comments below:

> Last year, or the previous year, I think 2017 it was, my granddad died. I was given a week's special leave for that which I was really appreciative of. A few months later, my current sister's husband was tragically killed walking home. I had to deal with that and I was only given three days' leave. The policy for dealing with grieve, the policy reads a week. I was told I have already had a week's special leave and so I couldn't get any more time off. I didn't understand that and I felt it was unfair because it

> just adds to your level of stress … all I did in this case was to call in sick in order to get days off. – P16 26/04/2019

At the end of the interview when asked if there was anything else he felt was important, he added:

> If I couldn't cope as a manager when I was bereaved, I don't expect my staff at lower-level bands to be able to cope because we are supposed to be setting the example. However, when it comes to the loss of a dear one, it is difficult to cope and ideally people should be given enough time away from work to grieve, otherwise it just puts pressure on people and then the stress becomes unbearable. – P16 26/04/2019

Similarly, the frustration behind this was highlighted by a junior manager:

> It was also the anniversary of my brother in-law's death, so kind of dealing with your personal circumstances as well as issues at work, I can't put them both I can't carry both of them it is stressful for me … – P20 02/05/2019

From the quote below, reactions to bereavement might trigger stress that can spill over to work:

> I came back to work very upset after the loss of a dear friend…I was only given a few days off to attend the funeral but on return, I felt distressed and was struggling most of the time to get work completed. This made me very stressed and impacted me negatively – P17-26/04/2019

In summary, this section has discussed the impact of caring responsibilities, relationship breakdown and bereavement as stressors for mental health support workers. The findings suggest that staff responsibilities towards caring for family members and the stress this cause can have a negative impact. Issues from a person's personal life and implications of the workplace may interfere and impact with home or family life. For example, people have different levels of caring responsibilities such as looking after elderly family members, children, and disabled relatives amongst others. These constitute an external care responsibility stressor confronting staff. These difficulties can cause interference at work and sickness absence; some people tend to overcome this situation by having to change jobs.

In the next section, I will discuss the theme of mental health challenges – a concept that emerged from employee health and wellbeing.

7.3. Mental health challenges

This theme was particularly significant as empowering employee wellbeing is important and can help staff develop the skills to manage stress and flourish while they do what they do best.

From discussions in Chapter 4, one in four people in the UK is suggested to experience mental health problems at some point in their lives. This is described as the "largest single cause of disability", representing well over 23% of the nation's total health burden (DOH 2011). Statistics also show that 1 in 6.8 people (14.7%) often experience one form of mental health problem in the workplace (Lelliott et al. 2008). Participants in this study acknowledged that mental health is not a one-size-fits-all but rather is individualised to the person involved. However, it is vital to find ways to best support people suffering from mental illness:

> It is one of those things we know that erhmm procedures don't fit one size and mental health erhmm … definitely mental health and stress isn't one size everybody is an individual and it is looking at that individual and how you can best support them. – P15 26/04/2019

> Procedures do not fit one size and definitely mental health and stress isn't one size for everybody, it is individualised, and it is all about looking at that individual and see how you can best support them. I do think that early intervention for staff with mental health breakdown would cut down a lot of the sickness leave. – P23 05/05/2019

The participant below expressed being depressed, suicidal and stressed. She further elaborated that being female was an added pressure making things harder:

> I am currently on the sick with depression and stress and almost near suicidal … I am fighting mental health issues and the main problem is there are a lot of broken people trying to fix people, staff mental health needs to be taken seriously. I think being a woman is making things worse if I may say because in my head there is so many domestic issues going on at the same. – P17 26/04/2019

P17's quote agrees with previous findings which suggest that women employed full time are twice as likely to have a common mental health problem as men who are employed in full-time positions (Stansfield et al. 2016). The above quote is also similar to those of P19 and P24 below in terms of struggling with their mental health and not

getting the support they needed. P19 also noted that not getting along with colleagues was a stressor impacting on her mental health:

> Everywhere I go things are not working the way I wanted. I am struggling with my mental health at the minute. I spoke to someone, and they have showed no concerns at all. Sometimes, it is hard to get along with fellow staff and this can be really stressful for me, it even affects my mental health and the way that I feel. – P19 30/04/2019

> Well occupational health suggested a daily walk to benefit my mental health, which was an excellent idea, but it never really worked as I am still stressed. Most days it is raining how I am supposed to walk in the rain? I am absent from work most of the time because of the stress of being mentally unwell coupled with getting less support. – P24 10/05/2019

In Section 6.3.3., findings suggested that staff-to-staff conflict and hostile or negative relationships with colleagues could impact on people's wider sense of wellbeing. P13 described her situation as being in a dark place. P33 commented on how people complained about the Trust not treating their staff who were suffering from poor mental health the way they should be treated. An HR worker agreed that people were not supported enough:

> I suppose there is body of evidence around compassion fatigue and mental health. I am currently in a dark place, and I think it is a really difficult thing for people when you are unwell as a carer to then be caring for people. This causes stress and anxiety. – P13 21/04/2019

> All too often we hear that the Trust does not treat staff with mental health issues the way they would treat their patients and staff find it very demoralising but of course it's mental health it is a serious issue but sadly as a mental health Trust I don't think we support people enough with their mental health and they end up being stressed. – P33 06/06/2019

Also, participants stated that it was difficult for people who were unwell themselves to look after people who are ill, and they suggested that the Trust was not supporting people enough with their mental health issues. This can again be linked to Chapter 6, where the ethos of care was discussed (see Section 6.3.4).

In my diary, I recorded similar experiences to those of the participants. The entry below was a few weeks after the completion of all interviews:

> I observed staff having a conversation regarding their mental health and stating that the Trust didn't really look after staff who had issues with depression or feeling suicidal. They said that all they get was a referral to occupational health. They emphasised a lack of support from the Trust and reiterated colleagues were going off sick because they could no longer cope with their mental health and felt unwell to care for others. – Field diary 10/07/2019

One of the managers stated that there were staff who reported low levels of wellbeing and engagement and who seemed not to be bothered by things anymore, which could in turn impact their motivation to work. Others generally presented with low levels of wellbeing but were happy to engage and put in their best to see things get done but did get burnt out during the process.

The manager went on to state that the Trust's executives and directors were often very motivated, presenting with high levels of wellbeing and engagement. However, managers fell under the category of people who were just trying to meet all deadlines and even though they could be classed as high performers they put themselves under a lot of pressure:

> I can tell from one of our presentations you have got people who have low levels of engagement and also report low levels of wellbeing and they are the people that are not bothered anymore, maybe they have seen everything change by time and that the way it was after 30 years in the NHS as you know you have got the category of staff who generally have a low level of wellbeing but are quite engaged and they are trying to do what they can and they get a bit of burn out through really just like giving it some hard slog and trying to get through there and you have got people with high levels of wellbeing and high levels of engagement and they can often be your executives, your directors erhmm and you have got the category where you got managers who are just on a hamster's wheel who are just going to meet all the deadlines and all the targets but they don't get the same satisfaction from their job, they are high performers but they put themselves under a lot of pressure to be high performers you see you know. – P34 10/06/2019

There were support workers who suggested that the Trust did not show enough concern when it came to the state and wellbeing of employees:

> The Trust doesn't care about how you feel or put your wellbeing into consideration, all they say is just get on and do your job, get on with the job that's all we hear all the time and as long as the paperwork are all up to date then that is what matters. I don't feel I am in a good place right

> now in terms of my wellbeing, but I feel no one cares and I just have to call in sick when I don't feel great. – P8 14/04/2019

This point was also made by P11. She felt that management did not put staff wellbeing into consideration when it came to allocating tasks, and noted that it was stressful:

> I work in the community and the bosses delegate duties without putting your wellbeing into consideration … just last week they asked me to go and see a patient alone who can barely leave the house for 20 minutes. It took me more than half an hour to attend to that patient and at the same time I was the only point of contact for the day so I get called upon at any time. It is stressful for me. – P11 09/05/2019

Workers may be relying on self-effort to manage stress caused by poor health and wellbeing. The participant below explained that she was leaning heavily on her spirituality and had also decided to make lifestyle changes by eating healthily and losing weight to manage stress and improve her health and wellbeing:

> My health and wellbeing at the moment is not very great. I think the only thing helping me right now is my spirituality, believing in God and I have always believed that tomorrow will be better … I have started to look into my physical health in terms of losing weight and eating more healthily in the hope that it will help me ease my stress and tension. – P14 26/04/2019

P17 did not feel she had had the best service even with referrals to the different occupational health services provided by the Trust; she thought they had not been useful. As a result, she was off sick with stress most of the time:

> Even though the Trust's employee health and wellbeing is made up of occupational health service provided by team prevent, I don't feel like I have had the best service at all … counselling and advice service is provided by Care First and again referral to this has not been helpful … I don't think I find them useful. I am off sick with stress the majority of the time because I am in a really dark place now and my health and wellbeing is in a mess. – P17 26/04/2019

Like P17, the participant below felt that visits to the occupational health team and conducting health risk assessments hadn't made any difference to how she was feeling:

> I was advised by occupational health on things I needed to do to ease my stress levels and enjoy a healthier lifestyle which could reduce risks to my health … I have done personal health risk assessments and onsite

> health checks and I still feel the same in terms of my health and wellbeing, it hasn't improved and am off work when I can't cope for the day. – P19 30/04/2019

P4 felt that work and life had been impacting on her wellbeing, and although she had self-referred to occupational health services there had been no response:

> I think work issues of life is affecting my health and wellbeing right now and I have self-referred to occupational health there is no response back as of yet and I am not coping presently I have been off sick with stress, and I have only just come back even though I don't feel great. – P4 03/04/2019

A member of staff believed that a solution to tackle the problem of stress at work was to introduce wellbeing strategies that could potentially be beneficial for employees:

> I personally think that to tackle stress for staff, there has to be some wellbeing strategies in place not necessarily referral to occupational health but doing things like yoga, mindfulness, massage, exercise and dietary advice would be beneficial. – P3 03/04/2019

However, a participant from Unison suggested it would be better for every staff member to have a wellness action plan:

> In terms of promoting good health and wellbeing for staff and reducing the rate of sickness absences triggered as a result of stress, it will be good practice that each member of staff has a WRAP (Wellness Recovery Action Plan) which is a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be. – P 27 (Unison) 16/05/2019

Anxiety, which is also a mental health challenge, can have a major impact in the workplace and can be described as a person's specific reaction to stress (Ross 2018). This study found that some staff were stressed as a result of being anxious:

> I would say my stress falls under the umbrella of mental health which is anxiety. I suffer a lot with anxiety, and I am constantly stressed as a result. I am anxious about the issues at home and then I get to work and become anxious about work re-evaluating events of the day, worried I might have done something not right. It is stressful to have anxiety problems and I don't think I am coping. – P13 21/04/2019

P20 appeared to have taken up exercise as a therapy to help with their anxiety from pressures at work. However, she felt able to cope by having a supportive team:

> I have had to resort to exercise to relieve me of my anxiety as it helps me release all the good endorphins that carry me through the first four to five hours of my shift. The Trust wasn't helping, and it became too much for me causing me a lot of stress and putting me under severe pressure. I had to speak to colleagues because we have a very supportive team at the moment, we share experience and you have people checking on you, it might seem little, but it does make a massive change and that's how I have been coping. – P20 02/05/2019

Participant 22 felt she had had no support from her manager regarding her anxiety which was causing stress. Instead, she was using swimming as a coping mechanism:

> I haven't had support from my manager regarding my anxiety which is causing me severe stress … all I do is go swimming at least once a week, great anxiety-buster and gets the endorphins going. – P22 04/05/2019

A member of the HR team noted that managing her own caseload and ensuring the safety of other members of staff was making her anxious constantly and affecting her health:

> Work for me has become stressful over time in terms of managing my own workload whilst ensuring other members of staff are kept safe and happy in their jobs … this is affecting my health and making me constantly anxious because sometimes I just think I am going to break. – P35 21/06/2019

In summary, the health and wellbeing of employees is vital, but staff reported being off sick with stress as a result of poor health and wellbeing. Staff did not feel that they were getting enough support or feeling any better after referrals to the Trust's occupational health and wellbeing services. This meant that there were still a lot of days lost to sickness as a result of stress. The union suggested implementing a Wellness Action Plan that could help staff get well and stay well. It is important that the health and wellbeing of staff are taken seriously because they are in a job where

they look after people who are mentally ill. This can be particularly challenging for staff, leading to excessive pressure and anxiety.

7.4. Concluding Remarks

This chapter has addressed the home domain as a stressor for mental health support workers. It provided insights into work-life balance and the difficulty of achieving this, especially when working in an organisation such as the NHS. This was due to a number of reasons, including poor pay, caring responsibilities and relationship breakdown, bereavement, and poor health and wellbeing resulting in mental health challenges and anxiety. The chapter has also demonstrated that staff themselves can be impacted negatively when they are not in a good place. Poor health and mental health breakdown are stressors that if not properly addressed can spill over into work. Mental health support workers are in a job where they care for patients who are mentally ill, and this can be emotionally challenging. This and other stressors from work such as voluminous caseloads can impact people negatively.

The findings suggest that stress is indeed multidimensional. However, mental health support workers expect that managers will be able to make positive impact in addressing multidimensional stressors; that is, stressors from both inside and outside the workplace. There are conflicting demands from work and home. Issues from a person's personal life and implications of the workplace may interfere and impact with home or family life. The nature of work, poor pay, relationship breakdown, bereavement, and poor health outside of the workplace can lead to stressful situations for staff. This can potentially have an impact on and interfere with their effectiveness in the workplace. Promoting health balance between home life and work life is important; this can be achieved by implementing and facilitating flexible working policies.

This elicits an area for future study, which bothers on whether and how extensively managers understand the dichotomy between work stress and home stress and the various approaches engaged in addressing this dichotomy. It elicits the question of the extent to which managers are willing to empathise with employees not just as professionals in the workplace, but also as people who belong to a family group with family responsibilities.

Chapter 8. Discussion

8.1. Introduction

The discussion chapter of this study will provide a critical discussion of the key findings. It reviews the research questions to discuss and evaluate the interpretations and understandings derived from the findings from the empirical data. It also positions the findings within the relevant academic literature reviewed in Chapter 2.

Adopting a qualitative approach has helped me to understand concepts, thoughts and experiences through gathering in-depth insights on this topic via interviews and the observations during my shifts which formed my ethnographic field notes. I have also attempted to make sense of and interpret the causes of stress among this unique group of people by studying the phenomenon in its natural setting (Aspers and Cote 2019). In response to this, the overarching aim of this research was to examine work-related stress among mental health workers in the NHS, considering its causes, manifestations and associated organisational issues, such as the institutional support mechanisms to address and reduce stress among staff.

8.2. Key aspects of mental health support workers' lived experience

8.2.1. Lack of professional recognition

The issue with a lack of professional recognition came after I noticed replaceability and not feeling valued as data themes.

The working lives of mental health support workers are characterised by the absence of professional recognition (see Chapter 5). The issue of professional recognition discussed here is related to the wider debate around the sociology of the professions and the importance of recognition as discussed in Chapter 2. Within the sociology of work, professions are categorised as occupations in that both require a degree of knowledge in a specific field (Monteiro 2015). It can be argued that every lawful occupation by which an individual earns their source of livelihood can be considered as their profession. However, there are certain criteria that make a profession a profession, including specific training and qualifications without which a professional is not allowed to practice, and mental health support workers certainly do not meet these criteria. Empirical evidence from this thesis suggests that there is more

precarity in the job roles of mental health support workers due to a lack of recognition. This may be because they do not need any form of qualification to get into the role, or because they do not need to meet any criteria to take on the role, which is therefore open to everyone. When job adverts are created for support workers, there are a lot of applicants willing to take on the job, meaning that they are not in demand compared to nurses or doctors.

Given that accountability for the jobs that support staff perform remains with the registered nurses, the process of delegation remains fraught, as discussed in Chapter 2. Therefore, it seems that mental health support workers are characterised by not having much control over the work they do, because a nurse can delegate to someone else, while they themselves do not have anyone to delegate any tasks to (as discussed in Section 5.4.4). In addition to a lack of control, support workers are expected to do jobs for which they are not qualified, such as urinalysis, wound care, drugs/alcohol testing, and so on. This is due to lack of resources, understaffing, and so forth. These are part of the duties of a qualified nurse. The main difference between a support worker and a qualified nurse is that support workers provide basic patient care and work under a registrant whereas a qualified nurse provides a higher level of patient care and co-ordination working under a doctor.

Even though their job description is clear on paper, it is evident that in practice the tasks undertaken may be beyond their remit, qualifications and training. Yet as the interview data have highlighted, taking on tasks that one is not trained to do, especially without supervision, can be particularly stressful.

There are also power effects in that if a nurse tells a support worker to do something, they are not in a position to say, “I don’t know how to do this.” Participants reported not feeling they had the power to refuse to work outside their role to achieve desired goals (see Chapter 5). Wider organisational constraints regarding financial difficulties, and other resource constraints such as staffing, therefore, have a direct impact on how mental health support workers do their job. A number of participants provided examples of where they had an imbalance of power by being told what to do even though it did not suit their requirements. This imbalance of power between them and nurses was attributed to feeling insecure in their jobs.

The findings also suggest that lack of professional recognition leads to lack of involvement in decision making. Support workers do not feel they are taken seriously as professionals. This is not surprising because they are not regarded as professionals. However, what was surprising was the fact that, as I highlighted in the previous chapters, most registered nurses find mental health support workers invaluable in terms of their contribution towards the delivery of care to patients, and so on. It is interesting that they see them as invaluable to the team, but at the same time, they are seen as a passive and invisible group. In addition to the pressures that they face, these people operate under tough working conditions where they experience abuse and violence from their patients. This is deemed as part of their job and a symptom of the patient's condition. As such, there are situations when too much is expected from mental health workers. Coupled with the fears about being blamed when things go wrong (see Chapter 5 for details), the lack of control in such situations appears to be a key stressor.

As discussed in Section 5.4.2, some research participants highlighted the lack of recognition that mental health support workers have within the workforce, which I suggest may be linked to their lack of professional recognition. Despite regularly undertaking continuing professional development to remain competent in their role, mental health support workers reported being assumed to be transient and expendable (see Chapter 5 for details). These reports contrast with the Trust's official policies, which do not suggest that different staff groups should be treated differently. Yet the participants reported experiences of being treated almost like second-class workers

It could of course be argued that this set of interconnected issues could be easily solved by giving mental health support workers professional recognition. This could enhance their status in the organisation; make them more visible, involved and in control. The literature on the sociology of professions has been exploring similar debates in the context of teaching assistants who, like mental health support workers, do not have professional recognition (Monteiro 2015). Yet would this really be a simple and straightforward solution? Professional recognition typically involves barriers to entry to a profession, for example through training or membership in a professional association, which might exclude some people from working. Also, there is a risk that if mental health support workers were given professional recognition, another layer of

not professionally recognised staff would take their place at the bottom of the organisational “pecking order”, which would only shift the problem from one group to another. These deliberations show that my research is dealing with very complex issues which would already have been resolved if they were straightforward to resolve.

At the moment, barriers to entry are low which may explain why there are so many people applying to get into the job role, contributing to perceptions of replaceability. In addition, the criteria required to take on the role are quite open to everyone, enabling wider participation in work and potentially being a stepping stone towards nurse training.

As such, part of a possible solution might be more local by positioning mental health support workers more explicitly as an integral part of a multidisciplinary mental healthcare team. This would require, however, more stability than many of the mental health support workers interviewed in this research appear to experience.

8.2.2. Replaceability

In contrast to doctors and nurses, who are scarce in the UK, mental health support workers can easily be replaced because of low entry barriers. This air of expendability may lead to fear of being dismissed for making a mistake. Although in the academic literature precarity is widely associated with non-permanent jobs, the analysis indicated an element of precarity in the interviewees’ accounts in terms of fear of losing their job. They reported feeling under pressure of not being allowed to make mistakes even though the pressures of understaffing increased the risk of mistakes.

It is understandable that easily replaceable mental health support workers have limited involvement in decision making. Yet in contrast to such assumed transience, my research participants stressed that this was a long-term career for many of them. People have evidently invested a lot of emotional effort into their job in order to work efficiently, despite the extensive pressure and poor pay; yet they are not asked about decisions regarding important issues at work. Even though they have the most contact with patients, they are at the bottom of the organisation’s “pecking order”, often sent to cover shifts and tasks that others are too busy to do. This was highlighted in the interview quotes provided in Chapter 6.

Therefore, the findings from my study indicate that a combination of replaceability, fear of making mistakes, and job insecurity can lead to or exacerbate stress among mental health support workers. Personally, I have been driven back several times to seeking more traditional employment due to the need for job security and financial stability. However, I am still in the job because I love caring for people and being a mental health support worker is giving me the opportunity to do so.

8.2.3. Involvement in decision making

Sentiments of easy replaceability have also been associated in the interview accounts with feelings of not being valued by the organisation. These were exacerbated by reports of experiences of a lack of involvement in decision making and employee voice, feeling undervalued, discrimination and lack of support (as discussed in Chapters 5 and 6). Overall, the analysis indicates that there are no formal mechanisms of employee voice or decision making. If you are easily replaceable, there are no mechanisms to bring in your own voice, which leads to lack of employee voice. Literature defines employee voice as the opportunity for employees to be involved in decision making and to express their views and opinions (Martin et al. 2015).

There are currently debates about employee voice leading to issues around power. The healthcare environment itself is deemed problematic given its long-standing reputation as a "hierarchical tradition with professional divides" (DoH 2005b:24), which may well highlight power inequalities between staff in assistant or support roles such as mental health support workers and other professionals such as doctors or nurses. Based on their position, there is no other way they feel they can be heard or involved in making decisions. As a result of the many barriers to employee voice such as fears around communicating their views to management, lack of recognition, lack of information and a poor life balance, there is very little incentive for a manager to give support workers a voice. These barriers are not necessarily just the lack of professional recognition but valuing them as persons and workers who work for the organisation.

For employees, self-expression in voice results in people feeling valued as well as creating opportunities for development, especially in terms of career progression (CIPD 2022). Also, there are potential individual and organisational benefits of employee engagement. Therefore, allowing mental health workers an element of

control over matters that affect them at work and creating mechanisms for them to communicate their views to management could contribute to positive relationships at work, especially between management and staff.

8.2.4. Lack of care

One surprising finding was a cluster of voices criticising the Trust for its lack of care towards staff, despite the fact that the NHS is a caring organisation at heart. As the empirical data in Chapter 6 suggest, the NHS's ethos of care was regarded as being directed only towards patients and much less so towards staff. This suggests that the culture of care is not universally lived by the organisation and at the line manager level.

This theme triggered questions such as whether line managers were actually skilled to deal with HR issues (Waring and Currie 2009), considering that most managers are clinicians by profession and, despite management training, may not have a managerial mind-set. The extant research on such clinician-managers has highlighted the challenges of undertaking such a hybrid role (Croft et al. 2015). As a clinician, a professional might see patient care as the important issue, but as a manager, professionals tend to focus on staff. Yet in an environment of resource constraints – and particularly understaffing, as discussed in Chapter 5 – patient care may take precedence over staff concerns.

The cumulative effect of stress

The research has indicated that there is a dynamic interplay between the organisational, workplace and home domains, with stressors originating in each building up over time. Research participants reported feeling under enormous pressure, and that their ability to cope with stress at work was affected by their personal circumstances and vice versa. It needs to be recognised that the research participants are resilient professionals who work under very stressful circumstances, including the threat of violence against them, and for whom working long hours is unavoidable as discussed in Chapters 4 and 6. These highlight an important issue: participants need to be skilled to manage themselves, their work, their time and their work-life balance, taking active steps to mitigate against stress and pressures (Watson and Reissner 2022).

Stress can originate from both work and non-work domains, as highlighted in this study. Common work stressors identified include organisational change and innovation, the nature of the work environment, resource constraints, workload, manager-staff relationships, support (or lack thereof), organisational policies, lack of employee voice, lack of recognition, feeling undervalued and lack of involvement in decision making. Non-work stressors include caring responsibilities (including children and elderly relatives), bereavement, personal factors such as health concerns (mental health and anxiety) and poor pay.

When participants experienced stress, they adopted coping behaviours that acted as outlets for their stress, such as taking days off work, seeking more traditional employment due to fear of losing their job, self-effort and self-referral to occupational health, leaning on spirituality and making life style changes to manage stress. Some participants also showed a propensity to evade their problems through avoidance. These behaviours resulted from the previously mentioned lack of employee voice, support, control and recognition. These behaviours could extend the period of stress as the problems were not resolved.

At the same time, interview accounts by HR practitioners from the Trust suggested that common metrics such as sickness absence rate and retention were negatively impacted by poor financial wellbeing. Mental health support workers earn comparatively little money and may struggle to make ends meet, as some accounts provided in Chapter 7 indicate. Research participants expressed concerns that their job was not particularly well-paid, both in general terms and in comparison to doctors and nurses. They reported the following causality: if someone is hard up and struggling financially, then that pressure will spill into their work. This causality is also supported by research which found that employees under financial stress took an extra one or two days as sickness leave yearly to deal with their financial worries (HSE 2020).

Therefore, the cumulative effects of stress include a combination of stress in the workplace, the organisation and personal life. If multiple stressors exist simultaneously, they can quickly build up and make people feel overwhelmed and stressed (Watson and Reissner 2022).

8.3. Concluding Remarks

This discussion has brought together the complex dynamics of stress among mental health support workers. It brought together a more holistic understanding of stress at the workplace in that it should not be treated as a standalone phenomenon. Rather, the complexities of the demands of the workplace are always impacted on by other domains such as the organisation and home which means it is intricate and multi-faceted. There is almost a relationship between all three dimensions. While individually, these issues are known in the extant literature, this research connects them to better understand mental health support workers' lived experiences regarding stress at the workplace and beyond.

Thus, the stress process is an adept framework that enables the mapping of stress on multiple levels. It provides an interpretive understanding of stress in different contexts and in different domains. The main theory that was considered relevant to the data in this research was the Transactional Model of Stress and Coping. This theory considers not only of the individual's biological, psychological and physical experiences of stress but also the social impact of stress and coping mechanisms. Stressors must invariably be studied in terms of their effect on an individual and as previously established in this thesis, stressors challenge adaptive capabilities causing strenuous experiences that inflict damage a person's wellbeing, behavioural, mental and social aspects.

The transactional model provided an explanation of the stress experienced by research participants. A primary appraisal led participants to decide whether the threat was relevant and harmful or not. A secondary appraisal allowed them to consider whether they had the capacity to deal with the stress. Lazarus and Folkman describe how individuals make a judgement on whether they believe they have the necessary social, physical, psychological and material resources in order to surmount the stress. Participants to this study mentioned mainly social and material aspects of coping.

Although the interview accounts and this discussion have been critical of some of the working practices in the NHS, there is no intention to assign blame to line managers, HR and occupational health professionals, the Trust or wider NHS. Rather, as will be detailed in Chapter 9, there are important implications for practice in terms of the role of line managers; their portfolio of work, their overall workload, and the

support available to them. Importantly, there needs to be better recognition that excellent patient care cannot be delivered by staff who are feeling under pressure, undervalued or otherwise stressed.

9.0. Conclusion

9.1. Introduction

Motivated by my own experiences as a mental health support worker, the overarching aim of this research was to examine work-related stress among mental health workers in one NHS Foundation Trust. I sought to examine its causes, manifestations and the institutional support mechanisms available to address and mitigate against work-related stress. I sought to answer the following overarching research question:

> *How do mental health support workers experience and mitigate the impact of stress across interrelated domains: organisational, workplace and home?*

The purpose of this final chapter is thus threefold. Firstly, it provides a summary answer to the research questions, derived from the analysis and interpretation of the data collected. Secondly, it outlines the key theoretical, empirical, practical and methodological contributions. Thirdly, it highlights the issues that require further research, such as the need to better understand the support mechanisms needed in reducing stress among mental health support workers, and also the lived experience of this group of staff in other NHS Trusts, including other support workers employed in other specialisms across the NHS.

9.2. Key Findings

The findings presented here are answers to the research question deriving from Chapters 5 to 7.

Chapter 5 discussed the key stressors from the organisational domain, such as resource constraints, organisational change and lack of stability in work teams. Organisational change causes stress for people and creates uncertainty because it affects working relations and puts pressure on people in different ways; for example, by being disruptive and increasing uncertainty.

Chapter 6 discussed stressors from the workplace domain through the voices of both managers and staff. It examined key stressors associated with the management domain, such as the ward environment and the perceived level of support available to support workers.

Chapter 7 addressed the life domain as a stressor for mental health support workers. It provided insights into work-life balance and the difficulty of achieving this, especially when working in an organisation such as the NHS. The stressors identified were financial worry, caring responsibilities, relationship breakdown, bereavement, poor health and wellbeing, anxiety and mental health issues.

Addition to knowledge

The findings in this study contrast with the picture painted elsewhere of what causes stress among doctors and nurses, such as workload, lack of clear roles, resource constraints, understaffing, and dealing with pain and suffering. The stressors that mental health support workers experience are some way different from those of their professionally recognised counterparts. They include a lack of professional recognition, replaceability, lack of care, feeling undervalued, and precarity of pay. These formed the cross-cutting themes from the three interrelated findings chapters. These issues distinguish my research participants from other qualified healthcare professionals, and I am going to be focusing on them in this section. There are some factors that underpin all five themes, such as working conditions, being positioned at the bottom of the hierarchy, fear of losing their jobs, being direct recipients of power, and the ease with which mental health support workers can get into trouble. It is therefore not only about the fact that this group of people are an understudied population; it is also about considering the factors affecting their working lives, which are characterised by professional distance rather than professional proximity.

9.3. Contributions

9.3.1. Theoretical contribution

This research contributes to the growing body of research on work-related stress, particularly in the healthcare sector. The literature review chapter of this study highlighted a number of limitations in work-related stress in mental health care such as focusing on one or two main occupational groups- nurses or doctors, and on one domain of workplace stress rather than a more holistic view of stress. Looking across some of the studies that I have analysed and reviewed including most of the research relating to work- related stress in healthcare, (Abbas et al. 2017; Khamisa et al. 2016; Parkyn and Wall 2020; Di Fabio 2017; Donaldson-Fielder et al. 2011; Havermans et

al. 2018; Mosadeghrad 2014), they tended to look at workplace stress as an isolated phenomenon in a particular domain of people's lives, typically the domain of work. Their findings suggest that extreme workload, poor pay, challenging patient behaviour, tough working conditions, uncertainty concerning treatment of patients, shortage of trained healthcare workers and several occupational health hazards are stressors inherent in healthcare.

However, through early attention to potential overlaps between different domains of a person's life, this research elucidates how factors originating in one life domain may affect experiences of stress in other life domains. In particular, the analysis identified three interrelated domains that interviewees alluded to: (1) organisational domain, (2) workplace domain, and (3) life domain. As explained in Section 3.6, Figure 3.4, the organisational domain comprises of a person's role and position in the organisational hierarchy, their involvement in organisational decision-making and opportunities to make their voice heard. The workplace domain relates to the allocation of work and the pressures and uncertainties caused by resource constraints and organisational change, as well as workplace relationships. The life domain refers to an individual's personal circumstances that may lead to experiences of stress (e.g., illness, caring responsibilities, bereavement).

Importantly, the analysis has identified a variety of relationships between these three domains. For instance, there is a clear relationship between a person's role and position in the organisational hierarchy and their level of pay. In the case of the mental health support workers participating in this research, this meant comparatively low levels of pay which can easily put pressure on their finances generally. Similarly, research participants connected the NHS's agenda of change, innovation, and efficiency (organisational domain) to frequent moving of staff between wards, affecting manager-staff-relationships (workplace domain). This, in turn, can lead to workplace misbehaviour that can impact on people's mental health (life domain). It is worth emphasising here that these domains and the relationships between them were derived from a specific dataset and may differ in other studies.

Nevertheless, such relationships between domains imply that people may bring their lives and worries from home into work and vice versa. It is therefore short-sighted to limit stress research on a single domain only (even though it is essential that experiences of stress in each domain are fully understood). Rather, this research

suggests a cumulative model of stress in which people are assumed to be able to cope with a certain number of stressors across the three domains. However, their overall experience of stress derives from all stressors added together.

These dynamics might be fruitfully illustrated through the metaphor of a bucket, which symbolises a person's capacity to cope with stress. The extant research assumes this bucket to be filled with water (stressors) from a single tap (domain). The implication is that the speed with which water flows into the bucket from the tap determines how quickly it fills. Once the bucket is full (that is, the person's maximum capacity to cope with stress is exhausted), the person is likely to experience stress. This conceptualisation of stress (typically focusing on the organisational or workplace domains) assumes that by reducing the stressors, people are less likely to experience stress.

However, this research suggests that the bucket might be filled with water (stressors) from multiple taps (domains). This means that the speed with which the bucket fills is a combination of water (stressors) from multiple domains. For example, a person who is experiencing stress from not being able to make their voice heard (organisational domain) and from experiencing workplace misbehaviours (workplace domain) can be expected to be less likely to cope with stressors in their life domain. Similarly, a person who is experiencing stress in their life domain can be expected to be less likely to cope with stressors deriving from the organisational or workplace domains. Put differently: the workplace, organisational and life domains are deeply intertwined. Stress does not exist in an isolated or specific domain of people's lives. This understanding of stress has important implications for practice.

9.3.2. Empirical contribution

This research makes some key conceptual contributions to the dearth of literature on mental health support workers. The first relates to their lack of professional recognition (see Section 8.2.1.), which perhaps should provide a basis for further research into this growing field of understudied groups of healthcare workers. According to McKenna (2007), support workers are core members of the nursing team, so they deserve to be registered or regulated.

The second concerns the issue of replaceability. Research participants are more vulnerable than doctors and nurses; there is evidence that they might be treated differently, and the tone of conversations regarding what you are going to do and whether you are fully prepared or qualified to do it differs between nurses and support workers. This again is very different from the more generic stresses that nurses and doctors are facing.

This research contributes to a greater understanding of mental health support workers by confirming that they are not just an understudied group; there are factors that make them more susceptible to stress. These factors are additional stressors in their work environment that other professionals such as doctors and nurses are not facing. These stressors are specific and intrinsic to the nature of their job and their position in the hierarchical ladder. This study interrogates balance in the context of the working lives of mental health support workers, many of whom are working very long hours coupled with taking on more roles than they are traditionally meant to do.

The experience of mental health support workers' working lives is not what literature suggests about work-life balance. What goes on in people's lives outside of work affects their work. We cannot separate these two domains as clearly as we would like (see Chapter 7). Rather, they should be reconceptualised as two separate domains, home and work, as suggested by Nippert-Eng (1996). Although it is advisable for people to see work as being part of life rather than a separate entity, the research findings suggest that if people cannot keep both as separate as they wish, they tend to experience conflict as work spills over into home, thereby leading to stressful conditions.

9.3.3. Practical contributions

The contributions to practice will be discussed at different levels.

Firstly, the research has significant potential to inform working practices within the NHS Foundation Trust that served as a case study, as well as similar trusts. By highlighting the human costs of organisational change (e.g. restructuring, innovation, efficiency) and working under significant resource constraints, the study has highlighted the need to ensure that the support mechanisms provided through the HR and Occupational Health functions meet the workforce's actual needs. The research has further emphasised the importance of making mental health workers a more

valued part of the organisation, for example by addressing the instability of their working environment and giving them a voice.

Secondly, the research has indicated research participants' concern about some line managers' behaviours. Recognising both the clinical background of many line managers in the Trust and the multiple pressures they are facing in their daily work, the research has put the spotlight on the need for more advanced training on mentoring and coaching, and structures that enable line managers to discuss complex cases and learn from one another. A more concerning theme regarding line managers was accounts of discrimination and bullying; the Trust is advised to investigate these. Although such incidents may not be part of a wider culture of discrimination (as suggested by several interview accounts), the research has indicated that perceptions of a culture of discrimination and bullying may prevent people from speaking up, exacerbating feelings of inferiority and unfairness.

Thirdly, beyond the Trust, this research has highlighted the complex debate regarding the professional status of mental health support workers. While there are arguments to be made for formal recognition to achieve a higher status and potentially also more involvement in decision making, the situation is much more complex. One advantage of the current position of mental health support workers within the wider NHS structure is that such roles are relatively easy to come by, which gives more people an opportunity to partake in paid work. Such work might also serve as a stepping stone towards a professionally recognised career path in healthcare. As such, professional recognition would prevent individuals who do not wish to (or could not afford to) undergo professional training from working in healthcare. However, an area for improvement could be a clearer career trajectory for those who wish to move from support worker to nurse or a specialist role.

Fourthly, from an HR perspective, this research has supported the current shift from work-related stress to a more holistic understanding of workplace wellbeing. The interview accounts and field notes have provided examples of the cumulative effects of stress, with pressure from one life domain impacting another and, in some research participants' words, "tipping people over the edge". This, in turn, has implications for organisations, including the Trust and the NHS as a whole. In the literature, there is a wider debate in the health sciences as doctors, nurses, dentists and even veterinarians are facing similar issues of bringing work home with them. To address

the problem, perhaps people could be taught techniques to help them switch off and manage the work-nonwork boundary more effectively. The focus should not be on providing, for example, subsidised gym membership, as is often done as part of such offerings, but on changes to policies and procedures that are more cognisant of the multiple pressures that staff may be under.

9.3.4. Methodological contribution

To investigate the experiences of individuals required a broadly ethnographic approach. An important methodological contribution of this study is that it has been carried out by a mental health support worker who acted as an insider-researcher (Giatzitzoglu 2018; Saunders et al. 2009; Humphrey 2007), and through an ethnographic methodology. I was immersed in the same situation as my research participants throughout the research process, which meant that I was able to compare and contrast my field notes with the interview accounts of my participants. By so doing, I have been able to show what being a mental health support worker is really like, and this forms a unique perspective on work-related stress.

For the duration of the study, I kept a research diary to capture my personal reflections and observations at work during my shift. The field diary added depth and richness to the data and provided additional support to the analysis. However, this required me to have a high level of researcher reflexivity, recognising my hybrid role as researcher and insider in different situations. It has, at times, been challenging to clearly separate these roles as the research was motivated by my own lived experiences as a mental health support worker. This, however, was illustrative of the strength I experienced throughout the lifecycle of this organisational ethnography (Mazzetti 2018).

The methodology has enabled me to complement extant research by painting a picture of the complex factors contributing to work-related stress among mental health support workers in a way that more quantitative approaches would not allow.

9.4. Reflections on the lived experiences of mental health support workers

From a personal perspective, this research, although very sensitive, has provided me with the opportunity to share my participants' lived experiences. As a mental health support worker, it was inevitable that my interpretation would reflect my personal experiences, but it was important to be able to appreciate the similarities as well as the differences between my experience and that of my participants (Silverman 2013). The lived experience diary was intended to function as an aide-memoire to highlight events of importance to me during my shift and to assist with the reflexivity required for sensitive research such as this.

I was also reflecting on my field notes as I transcribed them in relation to my own experience as a mental health support worker. This in turn facilitated my personal growth and self-experience, and even acted as a therapeutic tool (Van Manen 1990). The lived experience process helped me to highlight the differences and similarities between my own work experiences and those of my participants, and this became a reflexive space for me. The lived experience diary also helped to capture my own observations of some of my participants at work during my shifts, and these were integrated into the research during analysis. In relation to mental health support workers' experiences, this provided ideas and resources that I was able to incorporate and develop, such as the need to think more broadly about the kind of support that needs to be offered to staff and by whom. The analysis indicates that the findings represent the lived experiences of mental health support workers, partly resulting from continuous organisational changes in the name of efficiency and effectiveness.

The benefits of their lived experiences have been threefold. Firstly, from interviews, mental health support workers felt that the Trust's occupational health might not have been working very well. Of course, the Trust cannot afford to spend money on what is not working, but there is a need to consider an alternative for frontline staff and line managers to feel more supported when things are tough.

Secondly, further analysis of my lived experience diary suggests that there is scope for a bit of internal fact finding about what mental health support workers and line managers require in a bottom-up approach. Workers should be able to have conversations with people at the top and express their feelings and concerns, especially when they feel things are not going on as expected. Currently, it appears

that there are no mechanisms for these conversations to happen at a higher level. Also, the courses that managers attend: are they related to managing people or systems? Managers play a key role in supporting their staff as the first point of call when things are tough. This shapes their behaviours and how they interact with staff. For line managers, they also need support, but where do they get support and what is their support network? Do they have any mentors or coaches? How do managers see themselves? Are they being pushed into management roles; do they see their roles as clinicians, or do they see themselves as managers? In other words, should clinicians be clinicians and trained managers with managerial experience be recruited into the Trust instead?

Thirdly, the Trust and the wider NHS as an organisation should consider granting some kind of accreditation in the tasks that mental health support workers undertake and then recognise this professionally. As discussed in Chapter 8, this might not solve the problem completely, but it might resolve some of the issues around power play, lack of recognition and employee voice. However, if there are going to be people who will always be unrecognised and at the bottom of the food chain, this forms a wider debate as to how issues on precarity of work can be addressed.

Finally, rather than placing further demands on the already exhausted workforce, the organisation should see to it that it provides them with the support and resources they need, including fair pay, because better patient care starts with improving the working lives of staff. One of the key ways NHS Trusts can improve the wellbeing of their staff is by providing access to the right tools and resources so that they can feel financially secure and thus be able to carry out their duties effectively. For many businesses, and especially government-funded organisations like NHS Trusts, saving money is a key focus. However, major money-saving solutions are not always easy to implement, and healthcare reforms underpinned by the principles of neoliberal capitalism have been found to be both ineffective and costly (Rotarou and Sakellariou 2017). This research has highlighted the human costs of these exercises as mental health support workers experience stress and inequality in an increasingly dehumanised healthcare system.

9.5. Limitations

The outcome of this research is the provision of one possible interpretation of the experiences of mental health support workers based on an ethnographic lived experience diary and 35 semi-structured interviews with a variety of individuals on different band levels (see Chapter 3). The findings of this study cannot therefore be generalised to a wider population but provide a contribution to the body of work that is committed to understanding the causes of work-related stress specifically among mental health support workers.

As I have continued to work throughout the research process, it is possible that my views of working as a mental health support worker might have impacted on my understanding of my participants' accounts. However, to overcome this, I actively probed for both positive and negative aspects and stories.

This research also involved a single NHS Trust. It is possible that involving multiple NHS Trusts and support workers from other specialisms such as the general side of nursing might provide findings similar or different to those of my research participants.

9.6. Further research

The conclusions outlined in the previous chapter and the limitations outlined above have emphasised the need for further research in the following three areas:

Firstly, there is a need to better understand what support mechanisms would make the most difference in reducing stress among mental health support workers. Given the multitude of organisational, workplace and personal factors discussed in Chapters 5–7, it is clear that not all can be addressed. However, in order to enable organisations to target interventions, they need to know how to best focus their resources. A reliable evidence base will be central to this endeavour.

Secondly, there is a need to better understand the lived experiences of mental health support workers in other Trusts and of support workers employed in other specialisms across the NHS, to conclude more reliably whether similar dynamics are at play elsewhere. There may be a benefit in approaching such a study from different angles, such as a sociological perspective, to that taken in this research, but potentially completed within a psychological and/or economic perspective.

Thirdly, there is a need to better understand the role of line managers, who typically take the hybrid role of a clinician-manager, in the management of stress among their diverse teams (e.g. involving junior nurses, support workers). This research has indicated that line managers can play a crucial part in supporting their teams in difficult circumstances and ensuring fair and consistent behaviours towards all team members. This would reduce some of the stressors reported in the interview accounts.

9.7. Concluding Remarks

If the causes of work-related stress are to be addressed, there is a need for healthcare organisations and management to nurture cultures that attend to both high-quality patient care AND staff wellbeing. Ross's (2015) findings suggest that compassionate care means supporting staff as well as patients; this could become more central to working practices in the Trust and potentially mental healthcare more widely. While reduction in work-related stress will have a central role in this process, so will more supportive relationships at work as well as more opportunities for staff development.

Managers should develop skills and capacity to communicate to staff at work in a timely manner. To increase the prospects of managing and reducing stress in the workplace, managers should be provided with career opportunities and development, and with training and guidance on how to manage teams and allocate work, provide positive leadership styles and support and offer feedback to staff in a constructive and meaningful way. Organisations should be actively seeking to establish a two-way communication between managers and staff through different channels. They should make "speaking up" about problems that may occur an expected and accepted part of their culture.

For employees with mental health conditions, just as Allen and Fidderman (2019) advise, employers should develop wider awareness about the impact of these issues on employees and aim at providing support through a mental health at work plan, in addition to ensuring good working conditions and encouraging a healthy work-life balance.

Similarly, adopting a culture of understanding and openness that encourages constructive feedback, and avoids blame and criticism, are also fundamental to implementing a stress management strategy. However, building this kind of culture

requires that senior managers act as role models and take positive steps to ensure that Trust policies are implemented. Also, points that seek to continuously improve how the organisation manages stress at work should be reviewed.

References

Abbas, J.J., Smith, B., Poluta, M., and Valazquez, A. (2017). 'Improving health-care delivery in low -resource settings with nanotechnology: challenges in multi dimension'. *Nanobiomedicine* https://doi.org/10.1177/1849543517701158.

Adams, T.E., Jones, S.H and Ellis, C. (2015). *Auto ethnography: Understanding Qualitative Research*. London: Oxford University Press.

Adriaenssens, J., Hamelink, B., and Bogaert, P.V. (2017). "Predictors of occupational stress and well-being in First-Line Nurse Managers: A cross-sectional survey study". *International Journal of Nursing Studies.* 73, 85-89. http://doi.org/10.1016/j.ijnurstu.2017.05.007.

Agervold, M., and Mikkelsen E.G. (2004). 'Relationships between bullying, psychosocial work environment and individual stress reactions'. *Work and Stress.* 18:4, 336-351, DOI: 10.1080/02678370412331319794.

Aggarwal, N.T., Wilson R.S., Beck T.L, et al. (2014). "Perceived stress and change in cognitive function among adults 65 years and older", *Psychosomatic Medicine* Vol. 76(1), 80–85.

Aiken, L. H., Sloane, D. M., Clarke, S., Poghosyan, L., Cho, E., You, L., and Aungsuroch, Y. (2011). Importance of work environments on hospital outcomes in nine countries. *Journal of the International Society for Quality in Health Care*. 23, 357-364. doi:10.1093/intqhc/mzr022

Allbutt, and Masters, H. (2010). "Ethnography and the ethics of undertaking research in different mental healthcare settings". *Journal of Psychiatric and Mental Health Nursing, Vol.* 17(10), 210–215.

Allen, B. and Fidderman, H. (2019). *Your Health at Work: An Indispensable Guide to Physical and Mental Wellbeing*. Kogan Page, London.

Al-Ruzzieh, A.M., and Ayaad, O. (2021). "Work stress, coping strategies and health-related quality of life among nurses at an international specialized cancer centre". *Asian Pacific Journal of Cancer Prevention*. DOI: 10.31557/APJCP.2021.22.9.2995

Alvesson, M (2011). *Interpreting Interviews* London: SAGE Publications Ltd

Anderson R. (2003). “Stress at work: the current perspective”, *The Journal of The Royal Society for the Promotion of Health*, Vol. 1 Silverman, D. (2006) Interpreting Qualitative Data: Methods for Analyzing Talk, Text and Interaction. (3rd ed) London: Sage.

Aneshensel, C.S. (1996) ‘Consequences of Psychosocial Stress: The Universe of Stress Outcomes’ in Kaplan, H.B. ed., Psychosocial Stress: Perspectives on Structure, Theory, Life Course, and Methods’. (New York: Academic) 111–36.

Aneshensel, C.S. (2010) ‘Neighbourhood as a Social Context of the Stress Process’ in Avison W.R.et al. (2010) 35–52.

Argyris, C. (1960). *Understanding Organisational Behaviour*. Homewood, IL: Dorsey Press.

Arroba, T., James, K. (1990). ‘Reducing the Cost of Stress: An Organisational Model’. *Personnel Review,* Vol. 19(1), 21-27, http://doi.org/10.1108/00483489010143267.

Arthur, R. (2004). “Work-related stress, the blind men and the elephant”. *British Journal of Guidance and Counselling*. 32 (2), 157-169.

Ashong, G., Rogers, H., Botwe, B.O., and Anim-Sampong, S. (2015). *Effects of Occupational Stress and Coping Mechanisms Adopted by Radiographers in Ghana*. London: Elsevier.

Aspers, P., and Corte, U. (2019). “What is qualitative in qualitative research”. *Qualitative Sociology* 42(2): 139–160.Vol 73(2017), 85–92.

Au. A (2016). “The sociological study of stress: an analysis and critique of the stress process model”. *European Journal of Mental Health.* volume 12, pages 53-72.

Bacharach, S.B., Bamberger, P.A., and Sonnenstuhl, W.J, (2002). “Driven to drink: managerial control, work-related risk factors and employee problem drinking”. *Academy of Management Journal*, Vol.45 (4), 637-658.

Baehler, R., and Bryson, J. (2008). “Stress, Minister: government policy advisors and work stress”. *International Journal of Public Sector Management*, Vol. 21, Issue: 3, 257–270, https://doi.org/10.1108/09513550810863169.

Baker, C. (2020). Mental health statistics for England: Prevalence, Services and Funding. Briefing Paper. Available at www.parliament.uk/commons-library. (Accessed 12th July 2022).

Bakker, A. B., and Demerouti, E. (2007). "The job demands-resources model: state of the art", *Journal of Managerial Psychology*, Vol. 22(1), 309–328.

Bambra C., Whitehead M, Sowden A, Akers J, and Petticrew M. (2008). "A hard day's night? The effects of Compressed Work Week interventions on the health and wellbeing of shift workers: a systematic review". *Journal of Epidemiology and Community Health* 2008; 62, 764–777.

Barley, S., Ross, A (2015). *Understanding the Constructions of Identities by Young New Europeans* Abingdon, Oxon: Routledge R and Kunda, G (2004) *Gurus, Hired Guns and Warm Bodies: Itinerant experts in a knowledge economy* Princeton, New Jersey: Princeton University.

Barley, S.R., and Kunda, G. (1992). "Design and devotion: surges of rational normative ideologies of control in managerial discourse". *Administrative Science Quarterly,* Vol. 37(12), 369–399.

Bate, P. (1997). 'Whatever Happened to Organizational Anthropology? A Review of the Field of Organizational Ethnography and Anthropological Studies'. *Human Relations* 50 (9): 1147-1175.

Bate, S.P. (1997). Whatever happened to organisational Anthropology? A Review of the Field of Organisational Ethnography and Anthropological Studies. *Human Relations.* Vol (50). https://doi.org/10.1177/001872679705000905.

Beech, J., Bottery S., Mckenna, H. (2019). Closing the gap: key areas for action on the health and care workforce. Available at: https://www.kingsfund.org.uk. (Accessed on 20/06/22)

Beehr, T. and Schuler, R. (1980). *Stress in Organizations.* In K. Rowland and G. Ferris (Eds.), *Personnel Management*, Boston: New Perspectives.

Berger, P.L, and Luckmann, T. (1966). *The Social Construction of Reality: A Treatise in the Sociology of Knowledge.* 1st Edn. The Penguin Press: New York.

Bhatercherjee, A. (2012). *Social Science Research: Principles, Methods and Practice*. Textbooks collection. 3. http://scholarcommons.usf.edu/oa_textbooks/3.

Bhui, K., Dinos. S., Stansfeld, S., de Jong, B., et al. (2016). “Perceptions of work stress causes and effective interventions in employees working in public, private and non-governmental organisations: a qualitative study”. *Journal of British Journal of Psychiatric Bull.* 2016 Dec; 40(6), 318–325. Doi: 10.1192/pb.bp.115.050823. .

Billings, A. G. & Moos, R. H. (1981).The Role of Coping Responses and Social Resources in Attenuating the Stress of Life Events. Journal of Behavioural Medicine, 4(2), 139-157.

Blaxter, L, Hughes, C and Tight, M (2006). *How to Research.* 3rd Edition Maidenhead, Berks: Open University Press

Bolton, S.C. (2005). *Emotion Management in the Workplace.* London: Palgrave Macmillan, 2005.

Bonnar, A.J. (1999). “Stress at work: the beliefs and experiences of police superintendents”, *International Journal of Police Science and Management*, Vol.2(2), 285–302.

Boschi, H., Trenoveth, S., and Sheppard, Z. (2017), “Stress at work: factors associated with cognitive disorganization among private sector professionals”, *Health Psychology*, Vol. 4(2), 1–8.

Bosma H., Marmot, M., Hemingway, H., Nicholson, A.C., Brunner, E., and Stansfeld, S.A. (1997). “Low job control and risk of coronary heart disease in Whitehall II (prospective cohort) study”. BMJ 1997; 314, 558–565.

Boud, D., Keogh, R., and Walker, D. (1985). Promoting Reflection in Learning: A Model. Reflection: Turning Reflection into Learning. London: Routledge.

Boyaci, K., Sensoy, F., Beydag, K.E., and Kiyak, M (2014). “Stress and stress management in health institutions”. *Procedia – Social and Behavioural Sciences,* Vol. 152(2014), 470–475.

Braun, V. and Clarke, V. (2006) “Using thematic analysis in psychology”, *Qualitative Research in Psychology*, 3(2), 77–101.

Brinkmann, S and Kvale, S (2015) *Interviews: Learning the Craft of Qualitative Interviewing* 3rd Edition London: SAGE Publications Ltd.

Brooker, C., and Waugh, A. (2013). Foundations of Nursing Practice, Fundamentals of Holistic Care. 2nd Edition. Mosby: Elsevier.

Brule, G., and Morgan, R. (2018). “Working with stress: can we turn distress into eustress”? *Journal of Neuropsychology and Stress Management.* 3: 1-3. **DOI:** 10.31872/2018/JNSM-100104

Bryman, A. (2008). Social Research Methods. (3rd ed) New York: Oxford University Press.

Bryman, A. and Bell, E. (2015) *Business Research Methods*, 4th Edition, Oxford: Oxford University Press, London.

Bryman, A., and Bell, E. (2012). *Social Research Methods.* 4th Edition, Oxford University Press.

Buchan, J., Gershlick, B., Charlesworth, A., and Seccombe, I. (2019*). Falling short: the NHS workforce challenge.* Health Foundation.

Buchanan, D., and Alan, B. (2007). *Contextualising Methods Choice in Organizational Research: Organizational Research Methods*. 10(483). London: Sage.

Burke, R., Weir, T., and Duwors, R. (1980), “Work demands on administrators and spouse well-being”. *Journal of Human Relations*, Vol. 33(4), 253–278.

Callaghan, P. and Grundy, A. (2018). "Violence risk assessment and management in mental health: a conceptual, empirical and practice critique". *The Journal of Mental Health Training, Education and Practice*, Vol. 13 No. 1, pp.313. https://doi.org/10.1108/JMHTEP-04-2017-0027

Callan, V. J. (1993). Individual and organizational strategies for coping with organizational change. *Work & Stress*,7, 63-75.

Calnan, M., Wainwright, D., Forsyth, M., Wall, B., Almond, S. (2001). “Mental health and stress in the workplace: the case of general practice in the UK”. *Social Science and Medicine*, Vol 52(2001), 499-507.

Campbell, A., Layne, D., and Scott, E. (2021). “Relational Quality of Registered Nurses and Nursing Assistants: Influence on Patient Safety Culture”. *Journal of Healthcare* Basel. doi: 10.3390/healthcare9020189.

Caplan, R., Cobb, S., French, J. R. P., Jr., Harrison, R. V., and Pinneau, S., (1975). *Job Demands and Worker Health: Main Effects and Occupational Differences*. Washington: National Institute for Occupational Safety and Health:

Cash A. (2019). "The National Health Service in the UK". In Burke D., Godbole P., Cash A. (Eds.) *Hospital Transformation*. Springer, Cham.

Chambers, R., Schwartz, A., Boath, E, (2003). "Beating stress in the NHS". *British Medical Journal*. Vol 2003(326), 717.

Chang, E.M, Daly, J., Hancock, K.M., Bidewell, J.W., Johnson, A., Lambert, V.A and Lambert E. (2006). "The relationships among workplace stressors, coping methods, demographic characteristics and health in Australian nurses. *Journal of Professional Nursing*. DOI: 10.1016/j.profnurs.2005.12.002

Charles A, and Felton A. (2019). Exploring Young People's Experiences and Perceptions of Mental Health and Wellbeing using Photography, Child and Adolescent Mental Health, https://doi.org/10.1111/camh.12351.

Cheney, G., Zorn T.E., Planalp, S., and Lair, D.J (2008). "Meaningful Work and Personal/Social Well-Being Organisational Communication Engages the Meanings of Work. *Annals of the International Communication Association*. 32(1), 137-185.

Chou, L., Li, C., and Hu, S.C. (2014). "Job stress and burnout in hospital employees: comparisons of different medical professions in a regional hospital in Taiwan". *British Medical Journal*. *BMJ* 4:004185.doi 10.1136/bmjopen-2013004185..

CIPD (2015), "Absence Management". *Annual Survey Report*, 2015.

CIPD (2022). "Stress in the workplace". Available at: www.cipd.co.uk. (Accessed 2nd June 2022) .

Clark, A. and Chalmers, D. (1998). "The extended mind", *Analysis*. Vol. 58(1), 7–19

Colligan, T.W. and Higgins, E.M. (2006). "Workplace stress: etiology and consequences." *Workplace Behavioural Health,* Vol. 21(2), 89–97.

Collins, P.Y. (2020). "What is global mental health"? *Official Journal of the World Psychiatric Association*. 19(3). 256-266. https://doi.org/10.1002/wps.20728.

Compas, B. E., Connor-Smith, J. K., Saltzman, H., Thomsen, A. H., & Wadsworth, M. E. (2001). Coping With Stress during Childhood and Adolescence: Problems,

Progress, and Potential in Theory and Research. Psychological Bulletin, 127(1), 87-127.

Cook, I., and Crang, M. (1995). *Doing Ethnographies.* CATMOG 58. London: Institute of British Geographers.

Cooper, C. L. and S. Cartwright (1997). *Managing workplace stress.* London: Sage

Cooper, C.L, and Cartwright, S. (2007). "Stress-management interventions in the workplace: Stress counselling and stress audits". *British Journal of Guidance and Counselling,* Vol 22(1), 65-73.

Cooper, C.L., and Mitchell, S. (1990). "Nursing the critically ill and dying". *Human Relations,* Vol. 1990(43), 297–311.

Corbin, J., and Strauss, A. (1990). "Grounded Theory Research: Procedures, Canons, and Evaluative Criteria". *Journal of Qualitative Sociology*, Vol 13(1), 1990.

Cox, T, Griffith A, Rial-Gonzalez E, (2000) "Research on Work related Stress" European Agency for Safety and Health at Work available at https://osha.europa.eu/en/publications/reports/203. (Accessed: 23 April 2019).

Cox, T. (2004). "Editorial: work-related stress, risk management and management standards". *Work and Stress*, Vol.18 (2).

Cox, T., Griffiths, A., and Rial-Gonzalez. (2001). *Research on Work-Related Stress.* Office for Luxembourg: Official Publication of the European Communities.

Croft, C., Currie, G., and Lockett, A. (2015). "Broken 'two-way windows'? An exploration of professional hybrids". *Public Administration*, 93, 380–394, 89–90.

Currid, T.J. (2009). "The lived experience and meaning of stress in acute mental health nurses". *Journal of British Nursing.* DOI: 10.7748/ns.23.44.40.s51

Czarniawska, B (2014). *Social Science Research: From Field to Desk* London: SAGE Publications Ltd

Dall'Ora, C., Ball, J., Recio-Saucedo, A., and Griffiths, P. (2016). "Characteristics of shift work and their impact on employee performance and wellbeing: A literature review". *International Journal of Nursing Studies, Vol.* 57(10), 12–27.

Data Protection Act (1998). Available at: www.legislation.gov.uk. (Accessed 6th June 2019).

De Jonge, J., and Dormann, C. (2017). *Why is my job so stressful? Characteristics, Processes and Models of Stress at Work.* Google Books.

Delaney, KR., and Johnson, M.E. (2014). “Metasynthesis of Research on the Role of Psychiatric Inpatient Nurses: What is Important to Staff”? *Journal of the American Psychiatric Nurses Association.* 20(2). DOI: 10. 1177/1078390314527551.

Demir, D., and Rodwell, J. (2012). “Psychosocial antecedents and consequences of workplace aggression for hospital nurses”. *Journal of Nursing Scholarship*, Vol. 4(4), 376–384.

Denscombe, M (2007) *The Good Research Guide for small scale social research projects* 3rd Edition. Maidenhead, Berks: Open University Press.

Denzin, N. K. and Lincoln, Y. S. (2000). *Handbook of Qualitative Research.* (2nd ed) Thousand Oaks, CA: Sage.

Deondra, S., Scott, C., and Douglas. (2005). ‘Organisationally-induced work stress: The role of employee bureaucratic orientation’. *Personnel Review,* Vol.34 (22), 210-224, https://doi.org/10.1108/00483480510579439.

Department of Health. (1999) National Service Framework for Mental Health: Modern standards and service models. London: Department of Health.

Department of Health. (2000). The NHS Plan. A plan for investment. A plan for reform. London: Department of Health.

Department of Health. (2005b). *Creating a Patient-Led NHS. Delivering the NHS Improvement Plan*. London: Department of Health.

Department of Health. (2008a) Improving Access to Psychological Therapies. Implementation Plan: National Guidelines for Regional Delivery. London: Department of Health.

Department of Health. (2009). 'Not Alone': A guide for the better protection of lone workers in the NHS. London: Department of Health.

Department of Health. (2011a). No health without mental health: a cross-government mental health outcomes strategy for people of all ages. London: Department of Health

Dewe P., and Cooper, C. (2021). *Work and Stress: A research Overview*. 1st Edition: Routledge

Dewe, P.J., O'Driscoll, P.M, and Cooper, C.L. (2012). Theories of Psychological Stress at Work. In R.J Gatchel and I.Z Schultz (eds) *Handbook of Occupational Health and Wellbeing.* Springer: New York. 23-38.

Di Fabio, A. (2017). "The psychology of sustainability and sustainable development for well-being in organizations". https://doi.org/10.3389/fpsyg.2017.01534

Dickens GL, Ion R, Waters C, Atlantis E, Everett B (2019). "Mental health nurses' attitudes, experience, and knowledge regarding routine physical healthcare: systematic, integrative review of studies involving 7,549 nurses working in mental health settings". *BMC Nurs*. 2019 Apr 26;18:16. doi: 10.1186/s12912-019-0339-x. PMID: 31057334; PMCID: PMC6485121.

Dickinson, T., and Wright, K.M. (2008). "Stress and burnout in forensic mental health nursing: a literature review". British Journal of Nursing. 17(2). https://doi.org/10.12968/bjon.2008.17.2.28133.

Diener, E., & Crandall, R. (1978). *Ethics in social and behavioral research.* Chicago Press.

Dingwall, R. (1997). 'Accounts, Interviews and Observations', in Miller, G. and Dingwall, R. (eds). *Context and Method in Qualitative Research*. London: Sage.

Dohrenwand, B.S., and Dohrenwand, B.P (1974). *Stressful Life Events*. John Wiley: New York.

Donaldson-Fielder, E., Yarker, J., and Lewis, R. (2011). *Preventing Stress in Organisations: How to Develop Positive Managers.* Wiley-Blackwell: Chichester.

Donnelly, L. (2015). "New figures showing soaring NHS stress leave". *The Telegraph,* August 1st, 2015.

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

Ekinci, Y. (2015). Designing Research Questionnaires for Business and Management Students London: SAGE Publications Ltd

Elster, J. (2007). *Explaining Social Behaviour: More Nuts and Bolts for the Social Sciences.* Cambridge: Cambridge University Press.

Eriksen, W., Bruusgaard, D. and Knardahl, S. (2003). Work factors as predictors of sickness absence: A three month prospective study of nurses' aides. *Occupational and Environmental Medicine*. 60, 271– 278.

Errisuriz, V.L., Pasch, E.K., and Perry, C.L. (2016). "Perceived stress and dietary choices: The moderating role of stress management". *Journal of Eating Behaviours*. Vol. 22(2), 211–216.

Fischer, F.M, Borges, F.N., and Rotenberg, L. (2006). "Work ability of health care shift workers: what matters"? *Chronobiology International,* Vol. 23(6), 1165–1179.

Flick, U (2007) *Designing Qualitative Research* London: SAGE Publications Ltd

Folkman, S. (2003). "Stress: appraisal and coping". *British Medical Journal, Quality and Safety*, Vol. 12(3), 221–226.

Folkman, S. (2013). *Stress: Appraisal and Coping.* Encyclopaedia of Behavioural Medicine. ISBN:978-1-4419-1004-2.

Folkman, S., Lazarus, R. S. (1988). Coping as a mediator of emotion. *Journal of Personal and Social Psychology. 54,* 466-75.

Folkman, S., Schaefer, C., and Lazarus, R. S., (1979). "Cognitive Processes as Mediators-of Stress and Coping". In V. Hamilton and D. M. Warburton (Eds.), *Human Stress and Cognition,* England: Wiley, 265–298.

Ford, W. (2021). New awareness day bringing nursing support roles to the 'forefront'. Available at; www.nursingtimes.net. (Accessed at 4th May 2022).

Foy, T.J. (2015). *Managing Workplace Stress for Increased Performance in an Irish Higher Education Institution*. PhD thesis, Walden University.

Freeburn, S., and Sinclair, M. (2009). "Mental health nursing students' experience of stress: burdened by a heavy load". *Journal of Psychiatric and Mental Health Nursing.* 16, 335-342.

Fujimoto, H, Hirota, M., Kodama, T., Greiner, C., and Hashimoto, T. (2017). "Violence exposure and resulting psychological effects suffered by psychiatric visiting nurses in Japan". *Journal of Psychiatry Mental Health Nursing, Vol.* 24(8), 638–647.

Fulcher, M., Barzega, G., Maina, G., Novara, F., and Ravizza, L. (1995). "Stress and managerial work: organisational culture and technological changes: a clinical study".

Journal of Managerial Psychology, Vol.10 (4), 3–8, https://doi.org?10.1108/02683949510084065.

Gangster, D.C., and Schaubroeck, J. (1991). “Work stress and employee health”. *Journal of Management*, Vol. 17(2), 235–271.

Gates, D.M, Gillespie, G.L, and Succop, P. (2011). “Violence against nurses and its impact on stress and productivity”. *Nursing Economics*, Vol 29, 59-67.

Geuens T., Bouhy D., Timmerman V. (2016). ‘The hnRNP family: insights into their role in health and disease’. *Hum Genet.* 2016 Aug;135(8):851-67. doi: 10.1007/s00439-016-1683-5. Epub 2016 May 23. PMID: 27215579; PMCID: PMC4947485.

Gharibi, V., Mokarami, H., Taban, A., and Yazdani Aval, M. (2016). “Effects of work-related stress on Work Ability Index amongst Iranian Workers”. *Safety and Health at Work*, Vol. 7(1), 43–48.

Giatzitzoglu, A, and Payne, G. (2018). “A 3-level model of insider ethnography”. *The Qualitative Report*, 23(5), 1149–1159. Retrieved from https://nsuworks.nova.edu/tqr/vol23/iss5/9.

Giatzitzoglu, A. (2018). “Being and naughtiness: An account of being an ethnographic-insider studying white, working class gym users”. *The Qualitative Report*, 23(3), 696–709. Retrieved from https://nsuworks.nova.edu/tqr/vol23/iss3/1 Aneshensel, C.S. (1992) ‘Social Stress: Theory and Research’, Annual Reviews of Sociology 18, 15–38.

Giga, S. I., Cooper, C. L., and Faragher, B. (2003). “The development of a framework for a comprehensive approach to stress management interventions at work”. *International Journal of Stress Management,* Vol. 10(4), 280–292.

Gilburt, H. (2018). Funding and staffing of NHS mental health providers: still waiting for parity. Available at: www.kingsfund.org.uk. (Accessed 1st June 2021).

Gioia D.A., Corley, K.G., Aimee, C., and Hamilton, L. (2012). ‘Seeking Qualitative Rigor in Inductive Research: Notes on the Gioia Methodology’. Organisational Research Methods. https://doi.org/10.1177/1094428112452151.

Goodrich, J., and Cornwell, J. (2008). Seeing the person in the patient. The Point of Care Review Paper. Available at: https://www.kingsfund.org.uk. (Accessed 10th July 2021).

Gray, D.E. (2004). *Doing research in the real world.* London, Thousand Oaks, CA: SAGE Publication.

Griffiths, L. (2001). Does seclusion have a role to play in modern health nursing?". *British Journal of Nursing*. 10(10), 656-61.

Griffiths, TL., Chater, N., Kemp, C., Perfors, A., and Tenebaum, J.B. (2010). Probabilistic models of cognition: Exploring representations and inductive biases. *Trends in Cognitive Sciences.* 14, 357- 364.

Grix, J. (2002). "Introducing Students to the Generic Terminology of Social Research". *Journal of Politics.* Vol. 22(3), 175-186.

Guba, E G and Lincoln, Y S (1994) 'Competing Paradigms in Qualitative Research' in Norman K Denzin and Yvonna S Lincoln Eds *Handbook of Qualitative Research* Thousand Oaks, CA: SAGE Publications.

Ham, C., and Murray, R. (2015). *Implementing the NHS Five-Year Forward View: Aligning Policies with the Plan.* The King's Fund.

Hammarberg, K., Kirkman, M., and de Lacey, S. (2016). "Qualitative research methods: when to use them and how to judge them". *Journal of Human Reproduction*. Vol. 31(3), 498–501, https://doi.org/10.1093/humrep/dev334.

Handy, C. (1993). *Understanding Organizations*. 4th Edition. London: Penguin Books.

Hanrahan NP, and Aiken LH. (2008). 'Psychiatric nurse reports on the quality of psychiatric care in general hospitals'. *Journal of Qualitative Management Health Care*. 2008 Jul-Sep; 17(3):210-7. doi: 10.1097/01.QMH.0000326725. 55460.af. PMID: 18641503; PMCID: PMC2582015.

Hargreaves, T. (2008). *Making Pro-Environmental Behaviour Work: An Ethnographic Case Study of Practice, Process and Power in the Workplace.* PhD thesis, University of East Anglia.

Harrison, D. (2011). *A Qualitative Exploration of Co-Worker and Client Relationship*. PhD thesis, Newcastle University, UK.

Harrison, R., Van. (1978). “Person-environment fit and job stress.” In C. L. Cooper and R. Payne (Eds.), *Stress at Work*. New York: Wiley, 175–205.

Hassard, J., Teoh, K., Cox, T., and Dewe, P. (2014). *Calculating the Cost Work-Related Stress and Psychosocial Risks. European Risk Observatory, Literature Review.* London: Birkbeck College.

Hassard, J., Teoh, K.R., Visockaite, G., Dewe, P., and Cox, T. (2018). “The cost of work-related stress to society: A systematic review”. *Journal of Occupational Health Psychology,* Vol. 23(1), 1–17.

Havermans, B.M., Brouwers, E.P.M., Hoek, R.J.A., Anema, J.R., Van der Beek, A.J., and Boot, C.R.L. (2018). “Work stress prevention needs of employees and supervisors”, *BMC Public Health* 18(1):642. https://doi.org/10.1186/s12889-018-5535-1

Hazelhof T.J.G.M., Schoonhoven L., van Gaal B.G.I., Koopmans R.T.C.M. and Gerritsen D.L. (2016). “Nursing staff stress from challenging behaviour of residents with dementia: a concept analysis”. *International Nursing Review* Vol, 63, 507–516.

Health and Safety Executive (2001). *Tackling Work-Related Stress: A Guide for Employees*. Sudbury: HSE Books.

Health and Safety Executive (2020). *Work-related stress*. Available at: www.hse.gov.uk. (Accessed: 5th June 2020).

Health and Safety Executive (2021). *Work-related stress, anxiety or depression statistics in Great Britain 2021*. Available at: www.hse.gov.uk. (Accessed 10th June 2022).

Health Education England (2020). Working differently together: Progressing a one workforce approach. Available at www.hee.nhs.uk. (Accessed 9th February 2022).

Henshall, C., Doherty, A., Green, H. *et al.* (2018). ‘The role of the assistant practitioner in the clinical setting: a focus group study’. *BMC Health Service Research.* 18, 695 https://doi.org/10.1186/s12913-018-3506-y.

Herriot, P. (2001). *The Employment Relationship: A Psychological Perspective*. Hove: *Routledge*.

Hinkle, L. E. (1973). “The concept of ‘stress’ in the biological and social sciences”. *Science, Medicine and Man,* Vol. 1973 (1), 31–48.

Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44*(3), 513–524. https://doi.org/10.1037/0003-066X.44.3.513

Hoboubi, N., Choobineh, A., Ghanavati, F.K., Kesharvazi, S., and Hosseini, A.A. (2017). “The Impact of job stress and job satisfaction on workforce productivity in an Iranian petrochemical industry”. *Safety and Health at Work*, Vol. 8(1), 67–71.

Hochwarter, A., Witt, L., Treadway, D., and Ferris, G. (2006). “The interaction of social skill and organisational support in job performance”. *Journal of Applied Psychology.* 91 (2), 482-489.

Hoel, H., Sparks, K., and Cooper, C.L. (2001). *The Cost of Violence/Stress at Work and the Benefits of a Violence/Stress-Free Working Environment*. International Labour Organisation, Geneva.

Hoffman, S.G., Asnaani, A., Vonk, I.J., Sawyer, A.T, and Fang, A. (2012). “The efficacy of cognitive behavioural therapy: a review of meta analyses”. *Cognitive Therapy and Research*, Vol. 36(5), 427–440.

Holman, D., and Rafferty, A. (2017). The convergence and divergence of job discretion between occupations and institutional regimes in Europe from 1995 to 2010. Journal of Management Studies, 55(4), 619-647. https://doi.org/10.1111/joms.1226.

Holmberg, C., Caro, J., Sobis., I. (2018). “Job satisfaction among Swedish mental health nursing personnel: Revisiting the two-factory theory”. *International Journal of Mental Health Nursing.* Vol. 27 (2), 581–592. https://doi.org/10.1111/inm.12339.

Holmes, T., & Rahe, R. (1967). “The Social Readjustment Rating Scale”. *Journal of Psychosomatic Research, 12,* (4), p. 213–233.

Holmgren, K., Sandheimer, C., Mardby, A., and Larsson, M. (2016). “Early identification in primary health care for people at risk of sick leave due to work-related stress”. Study protocol of a randomised controlled trial (RCT).

Horan, K.A, Moeller, M.T., Singh, R.S., Wasson, R., O’Brien, W.H., Matthews, R.A., Jex, S.M, and Barratt, C.L. (2018). “Supervisor support for stress management and intervention process”. *International Journal of Workplace Health and Management.* https://doi.org/10.1108/IJWHM-12-2017-0113.

Hua, Y. (2010). “A model of workplace environment satisfaction, collaboration experience, and perceived collaboration effectiveness: A survey instrument”. *International Journal of Facility Management*, Vol. 1(2), 1-21.

Humpel, N., and Caputi, P. (2001). “Exploring the relationship between work stress, years of experience and emotional competency using a sample of Australian mental health nurses”. *Journal of psychiatric and mental health nursing*, *8*(5), 399–403. https://doi.org/10.1046/j.1365-2850.2001.00409.x

Humphrey, C (2007) ‘Insider-outsider: Activating the hyphen’. *Action Research* 5(1) 11-26.

Iles, V., and Sutherland, K. (2001). *Managing Change in the NHS: Organizational Change. A Review for Healthcare Managers, Professionals and Researchers.*

Ilmarinen, J. (2007). “The Work Ability Index (WAI)”. *Occupational Medicine,* Vol. 57(2), 160. https://doi.org/10.1093/occmed/kqm008.

Imison, C., Castle-Clarke, S and Watson R (2016). Reshaping the workforce to deliver the care patients need. *Research Report.* Nuffield Trust.

Iversen AC, van Staden L, Hughes JH, Greenberg N, Hotopf M, et al. (2011). ‘The stigma of mental health problems and other barriers to care in the UK Armed Forces’. *BMC Health Serv Res.* 2011 Feb 10;11:31. doi: 10.1186/1472-6963-11-31. PMID: 21310027; PMCID: PMC3048487.

Jain, A.K., Giga, S.I., and Cooper, C.L. (2013). “Perceived organisational support as a moderator in the relationship between organisational stressors and organizational citizenship behaviour”. *International Journal of Organisational Analysis,* Vol. 21(3), 313–334. https://doi.org/10.1108/IJOA-Mar-2012-0574.

Jakobsen, L.M., Jorgensen, F.B.A., and Birthe, L (2016). “Emotion work within eldercare and depressive symptoms: A cross-sectional multi-level study assessing the association between externally observed emotion work and self-reported depressive symptoms among Danish eldercare workers”. *International Journal of Nursing Studies*, Vol. 62 (2016) 183–192.

Jick, T. (1979). “Mixing qualitative and quantitative methods: Triangulation in action”, *Administration Science Quarterly,* Vol. 24(4), 602–611.

Jick, T. D., and Payne, R. (1980). "Stress at work". *The Organizational Behaviour Teaching Journal,* Vol. 5(3), 50–55.

Jones, J., and Lyneham, J. (2000). *Perceptions and Prevalence of Violence in Australian Nursing*. Bathurst: Charles Sturt University.

Joyce, K., Critchley, J.A., Bambra, C. (2009). "Flexible working conditions and their effects on employee health and wellbeing (Protocol)". *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD008009. DOI: 10.1002/14651858. CD008009.

Kaldenberg, D.O. and Becker, B.W. (1992). "Workload and psychological strain: a French Rodgers and Cobb hypothesis". *Journal of Organisational Behaviour*, Vol. 13(6), 617- 624.

Karasek, R. A. (1979), "Job demands, job control and mental strain: Implications for job redesign", *Administrative Science Quarterly*, Vol. 24(1), 285–308.

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

Karkoulian, S., Srour, J., and Sinan, T. (2016). "A gender perspective on work-life balance, perceived stress and locus of control". *Journal of Business Research*, Vol. 2016(1), 6.

Kearns, J. (1986). "Stress at work: the challenge of change". *The Management of Health*, Vol. 1986(1), 2.

Keller A, Litzelman K., Wisk LE., Maddox T., Cheng ER., Creswell PD., and Witt WP (2012). 'Does the perception that stress affects health matter? The association with health and mortality'. *Health Psychol*. 2012 Sep;31(5):677-84. doi: 10.1037/a0026743. Epub 2011 Dec 26. PMID: 22201278; PMCID: PMC3374921.

Kerdijk, C., Kamp, J.V., and Polman, R. (2016). "The Influence of the Social Environment Context in Stress and Coping in Sport". *Frontiers in Psychology*. Vol. 2016(7), 875.

Kerr, K., Oram, J., Tonson, H., and Shum, D. (2017). "Health care workers' experiences of aggression", *Archives of Psychiatry Nursing,* Vol. 31(5), 457–462.

Khamisa, N., Peltzer, K., Llic, D., and Oldenburg, B. (2016). "Work-related stress, burnout, job satisfaction and general health of nurses: A follow-up study". *International Journal of Nursing Practice,* Vol. 22. (6), 538–548.

King, N. (2004) "Using interviews in qualitative research". In *Essential Guide to Qualitative Methods in Organizational Research*. London: Sage, 11–22.

Kipping, C. (2000). 'Stress and Coping in Mental Health Nursing'. PhD. University of London: London.

Kirkegaard, T., and Brinkmann, S. (2015). "Rewriting stress: Toward a cultural psychology of collective stress at work". *Journal of Culture and Psychology*, Vol. 21 (1), 81–94.

Knaak S, Mantler E, Szeto A. (2017). 'Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Health care Management Forum*. 30(2):111-116. doi: 10.1177/0840470416679413.

Koinis, A., Giannou, V., Angelaina, S., Stratou, E., and Saridi, M. (2015). "The Impact of Healthcare Workers Job Environment on their Mental-emotional Health, Coping Strategies: *The Case of a Local General Hospital. Journal of Health Psychology Research*. 13; 3(1):1984. Doi: 10.4081/hpr.2015.1984. PMID: 26973958; PMCID: PMC4768542.

Koval, L. (2016). 'Stress management among health care professionals: Psychological methods and coping techniques'. Degree Programme in Nursing. Laurea University of Applied Sciences.

Kulkami, P, Gooi, R., Kulkami, P., Bhatwadeker, M, Thatte, N., and Anavkar, V. (2014). "Stress among care givers: The impact of nursing a relative with cancer". *Indian Journal of Palliative Care.* Vol. 20(1), 31–39.

Kvale, S. (1996). *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage.

Lamb, D. and Cogan, N. (2016). "Coping with work-related stressors and building resilience in mental health workers: A comparative focus group study using interpretative phenomenological analysis". *Journal of Occupational and Organizational Psychology*, Vol. 89(3), 474–492.

Langley, A. (1999). ‘Strategies for theorizing from process data’. *Academy of Management Review*. Vol 24, Page 691-710.

Lazarus, R. and Launier, R. (1978). *Stress-Related Transactions between Person and Environment*. New York: Plenum Press.

Lazarus, R. S. (1990). Theory-based stress measurement. *Psychological Inquiry, 1*(1), 3–13. https://doi.org/10.1207/s15327965pli0101_1

Lazarus, R.S. (1991). “Progress on a cognitive-motivational-relational theory of emotion”. *American Psychologist*, Vol. 46(8), 819.

Lazarus, R.S. (1999). *Stress and Emotion: A New Synthesis*. New York: Springer.

Lazarus, R.S. (1999). Stress and emotion: A new synthesis. Springer Publishing.

Lazarus, R.S., and Folkman, S. (1984). *Stress, Appraisal and Coping*. New York: Springer Publishing.

Lee, B., Seo, D., Lee, J., Deon, H, and Han, D. (2016). “Impact of work environment and work-related stress on turnover intention in physical therapists”. *Journal of Physical Therapy Science, Vol.* 28(8), 2358–2361.

Leka, S., and Jain, A. (2016*). International Initiatives to Tackle Psychosocial Risks and promote Mental Health in the Workplace: Is There a Good Balance in Policy and Practice?* Springer: Switzerland. 23–43.

Leka, S., Griffiths, A., and Cox, T. (2004) *Work Organization and Stress*. 3rd Edition. United Kingdom. World Health Organization

Lelliott, P., Boardman, J., Harvey, S., Henderson, M., Knapp, M., and Tulloch, S. (2008). *Mental health and work.* Royal College of Psychiatrists, London, UK.

Lewis, J. and Ritchie, J. (2003). 'Generalising from Qualitative Research', in Ritchie, J. and Lewis, J.(eds) *Qualitative Research Practice*. London: Sage, pp. 264-286.

Lewis, S and Cooper, C L (2005) *Work-Life Integration - Case Studies of Organisational Change* Chichester, West Sussex: John Wiley & Sons Ltd

Li, C. T., Cao, J., and Li, T. M. (2016). Eustress or distress: An empirical study of perceived stress in everyday college life. In *Proceedings of the 2016 ACM International Joint Conference on Pervasive and Ubiquitous Computing: Adjunct* (1209-1217). ACM.

Light, D.W. (2003). Lessons from the British experience. American Journal of Public Health. 93(1):25-30. doi: 10.2105/ajph.93.1.25.

Lim J., Bogossian, F. and Ahern K. (2010) “Stress and coping in Australian nurses: a systematic review”. *International Nursing Review.* 57, 22–31.

Lincoln, Y. S. and Guba, G. E. (1985) Naturalistic Inquiry. Beverly Hills, CA: Sage.

Loerbroks, A., Weigl, M., Li, J., and Angerer, P. (2016). “Effort-reward imbalance and perceived quality of patient care: a cross-sectional study among physicians in Germany”. *BMC Public Health,* Vol. 16(1), 1.

Looker, T., and Gregson, O. (2008). *Managing stress*. 3rd ed. Hodder and Stoughton: John Murray Press

Lornudd, M., Bergman, D., Sandahl, C., and Schwarz, U.T. (2016). “Healthcare managers’ leadership profiles in relation to perceptions of work stressors and stress”. *Leadership in Health Services,* Vol. 29(2), 185–200, https://doi.org/10.1108/LHS-06-2015-0016 .

Lu, C. (1999). Work motivation, job stress, and employees’ well-being”. *Journal of Applied Management Studies,* Vol. 8(1), 61–72.

Lumbers, M. (2018). “Approaches to leadership and managing change in the NHS”. *British Journal of Nursing*. Vol. 27(10). https://doi.org/10.12968/bjon.2018.27.10.554. Published online: 23 May 2018.

Lundmark, R., Hasson, H., Schwartz, U.V.T., Hasson, D., and Tafvelin, S. (2017). “Leading for change: line managers’ on the outcomes of an occupational health intervention”. *An International Journal of Work, Health and Organisation*. Vol. 21(3), 276–296.

MacDonald, K. M. (1995). *The Sociology of the Professions*. London: Sage.

MacDonald, K. M. (2006) 'Professional Work', in Korczynski, M., Hodson, R. and Edwards, P. K. (eds) *Social Theory at Work*. Oxford: Oxford University Press.

Machlowitz, M., (1980). *Workaholics. Living with Them, Working with Them*. Addison Wesley: Reading.

Mah, L.S., and Fiocco, A.J. (2016), “Can anxiety damage the brain?” *Current Opinion in Psychiatry*, Vol. 29(10), 56–63.

Malinowski, B. (1922). *Argonauts of the Western Pacific*. London: Routledge & Kegan Paul.

Mandi, I and Biletta, I (2018). European Foundation for the Improvement of Living and Working Conditions. *Overview of new forms of employment – 2018 update*. Luxembourg: Publications Office of the European Union. Online. Available from: https://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1649&context=intl (accessed 9 October 2020).

Mann, S and Cowburn, J,. (2005). "Emotional labour and stress within mental health nursing". Journal of Psychiatric and Mental Health Nursing. 12(2), 154-162.

Mark, G. (2008). *The Relationship between Workplace Stress, and Job Characteristics, Individual Differences and Mental Health*. PhD thesis submitted to Centre for Occupational and Health Psychology, School of Psychology, Cardiff University, UK.

Mark-Anthony, F. (2016). *Multi-sited Ethnography: Theory, Praxis and Locality in Contemporary Research*. 1st Edition, Routledge.

Martin, G., and Siebert, S. (2016). *Managing People and Organizations in Changing Contexts* (2nd ed.). Routledge. https://doi.org/10.4324/9781315767178.

Martin, G., Siebert, S., Howieson, B., and Bushfield, S. (2015). "The changing experience of work of consultants in NHS Scotland". *British Medical Association.* https://doi.org/10.20933/100001161.

Mason, J. (1996) Qualitative Researching. London; Thousand Oaks, CA: Sage.

Mawritz, M., Folger, R. and Latham, G. (2013), "Supervisor's exceeding difficult goals and abusive supervision: The mediating effects of hindrance stress, anger and anxiety", *Journal of Organizational Behaviour,* 35, 358–372.

Mazzetti, A. (2013). "The Role of Emotion Regulation in Job Stress and Well Being". *Research in Occupational Stress and Well-being.* Vol 11, 283-310. ISSN: 1479-3555/doi:10.1108/S1479-3555 (2013)0000011014.

Mazzetti, A. (2016). "An exploration of the emotional impact of organisational ethnography". *Journal of Organizational Ethnography,* 5(3), 304–316. https://doi.org/10.1108/JOE-07-2016-0018.

McKay, S, Craw, M., and Chopra, D. (2006). *Migrant workers in England and Wales: An Assessment of Migrant Worker Health and Safety Risks.* HSE Books: London.

McKenna, H. (2018). The NHS at 70: Are we expecting too much from the NHS? Available at: www.kingsfund.org.uk. (Accessed 1st June 2021).

McVicar, A. (2003). "Workplace stress in nursing: a literature review". *Advanced Nursing*, Vol. 44(6), 633–642.

Melynk, T.S. (2011). *A Sociological Perspective on Stress, Health, and Coping, and an Examination of a Proposed Coping Framework: The Coping Repertoire Approach.* MSc thesis, University of Manitoba, Winnipeg.

Meurs, J. A., & Perrewé, P. L. (2011). Cognitive activation theory of stress: An integrative theoretical approach to work stress. *Journal of Management, 37*(4), 1043–1068. https://doi.org/10.1177/0149206310387303

Michie, S. (2002), "Causes and management of stress at work". *Journal of Occupational and Environmental Medicine,* Vol. 59(1), 67–72.

Miles, M., and Huberman, M. (1984). *Qualitative Data Analysis*. Sage: Beverly Hills CA.

Millburn, A. (2017). "Technology and innovation are key to saving the NHS". *The Guardian*, 2017.

Miller, J and Glassner, B (2011) 'The "Inside" and the "Outside": Finding Realities in Interviews' in David Silverman Ed *Qualitative Research* 3rd Edition London: SAGE Publications Ltd

Milligan-Saville, J.S., Tan, L., Gayed, A., et al. (2017). "Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial". *Lancet Psychiatry*, Vol. 4(11), 850–858.

Mills, H., Reiss, N., & Dombeck, M. (2018). Types of Stressors (Eustress vs. Distress). Retrieved from https://www.mentalhelp.net/articles/types-of-stressors-eustress-vs-distress/

Mirela, B. and C. Madalina-Andriana (2011). "Organizational Stress and Its Impact on Work Performance". Annals of the University of Oradea, *Economic Science Series*, 333-337.

Monteiro A.R. (2015) “Sociology of the Professions”. In *The Teaching Profession.* Springer Briefs in Education. Springer, Cham. https://doi.org/10.1007/978-3-319-12130-7_4

Moore, K.A., and Cooper, C.L. (1996). Stress in mental health professionals: a theoretical overview. *International Journal of Social Psychiatry*. 1996 Summer; 42(2):82-9. Doi: 10.1177/002076409604200202. PMID: 8811392.

Moreno-Smith, M., Lutgendorf, S.K., and Sood, A.K. (2010). “Impact of stress on cancer metastasis”. *Journal of Future Oncology.* 2010 Dec; 6(12):1863-81. doi: 10.2217/fon.10.142. PMID: 21142861; PMCID: PMC3037818.

Mortensen, M.N., and Needham, C. (2022). “‘I do not want to be one of her favourites’. Emotional display and the co-production of frontline care services”. *Public Management Review*. DOI:10.1080/14719037.2021.2013071.

Mosadeghrad, A.M. (2014). “Occupational stress and its consequences: Implications for health policy and management”. *Leadership in Health Services,* Vol. 27(3), 224–239. https://doi.org/10.1108/LHS-07-2013-0032.

Mostafa, A.M (2016). ‘High Performance HR Practices, Work Stress and Quit Intentions in the Public Health Sector: Does person-organisation fit matter’? *Public Management Review*, 18 (8).

Naylor, C., Das, P., Ross, S., Honeyman, M., Thompson, J., and Gilburt, H. (2016). Bringing together physical and mental health, a new frontier for integrated care. Available at: www.kingsfund.org.uk. (Accessed 7th July 2020).

NHS Digital (2017). NHS Sickness Absence Rates: July 2017 to September 2017. Available at: https://digital.nhs.uk. (Accessed 19th July 2019).

NHS Digital (2018). Mental Health Act Statistics, Annual Figures 2018-2019. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual -figures/2018-19.

NHS Digital (2022). Mental health and learning disabilities workforce in the NHS. Available at: https://digital.nhs.uk. (Accessed 10th May 2022).

NHS England (2016). The 2015 NHS Staff Survey in England. Available at: https://www.england.nhs.uk. (Accessed: 3rd October 2019).

NHS England (2022). Health care support worker programme. Available at: https://www.england.nhs.uk. (Accessed: 2nd May 2022).

Nippert-Eng, C. (1996). Calendars and keys: The classification of 'home' and 'work'. Sociological Forum. 11, 563–582 (1996). https://doi.org/10.1007/BF02408393.

Nowell, L.S., Norris, J.M., White, D.E., and Moules, N.J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*. https://doi.org/10.1177/160917733847.

O'Connor, K., Muller Neff, D., and Pitman, S. (2018). "Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants". *Journal of European Psychiatry.* 53, 74-99. Doi: 10.1016/j.eurpsy.2018.06.003.

O'Connor, S. (2016). "Present at work yet far from in good health". *Financial Times*, 14 September,2016.

O'Dowd, A. (2021). "NHS staff's levels rose last year as covid pandemic took its toll". *British Medical Journal*. 2021; 372. doi: https://doi.org/10.1136/bmj.n703

Orzechowska, A., Zajączkowska, M., Talarowska, M., and Gałecki, P. (2013). "Depression and ways of coping with stress: a preliminary study. *International Medical Journal of Experimental and Clinical Research*, *19*, 1050–1056. https://doi.org/10.12659/MSM.889778.

Ouellet-Morin, I., Odgers, C.L., Danese, A., et al. (2011), "Blunted Cortisol responses to stress signal, social and behavioural problems among maltreated/bullied 12-year-old children". *Biological Psychiatry* Vol. 70(11), 1016–1023.

Ozeki, Y., Hory, H., Teraishi, T., Kawamoto, Y., and Kinoshita, Y. (2010), "Relationships between psychological distress, coping styles, and HPA axis reactivity in healthy adults", *Journal of Psychiatric Research*, Vol. 44(2010), 865–873.

Paoli, P., (1997). *Second Survey on Working Conditions*. European Foundation for the Improvement of Living and Working Conditions: Dublin.

Parkyn, M., and Wall, T. (2020). 'Workplace Stress Management'. In: Leal Filho W., Wall T., Azul A.M., Brandli L., Özuyar P.G. (eds) Good Health and Well-Being. *Encyclopaedia of the UN Sustainable Development Goals*. Springer, Cham. https://doi.org/10.1007/978-3-319-95681-7_27.

Pasaoglo, D, (2015), “Analysis of the relationship between human resources management practices and organizational commitment from a strategic perspective: Findings from the banking industry”. *Social and Behavioural Sciences, Vol.* 207(10), 315–324.

Pate, J., Martin, G., and Staines, H. (2000). “Exploring the relationship between the psychological contracts and organisational model and case study evidence”. *Journal of Strategic Change*. Vol. 9(8), 481.

Patton, M. Q. (2002). *Qualitative Research and Evaluation Methods*. 3rd Edition. London: Sage.

Pearlin, L.I. (1983) ‘Role Strains and Personal Stress’ in Kaplan, H.B ed., Psychosocial Stress: Trends in Theory and Research (New York: Academic) 3–32.

Pearlin, L.I. (1989) ‘The Sociological Study of Stress’, Journal of Health and Behavioural Science 30, 241–56.

Pearlin, L.I. and Bierman, A (2013) ‘Current Issues and Future Directions in Research into the Stress Process’, Handbook of the Sociology of Mental Health (2nd ed., New York etc.: Springer) 325–40 (DOI: 10.1007/978-94-007-4276-5_16).

Pearlin, L.I. and Lieberman, M.A. (1979) ‘Social Sources of Emotional Distress’ in R. SIMMONS, ed., Research in Community and Mental Health (Greenwich, Conn: JAI) 217–48.

Pearlin, L.I., Aneshensel C.S and Leblanc A.J (1997) ‘The Forms and Mechanisms of Stress Proliferation: The Case of AIDS Caregivers’, Journal of Health and Social Behavior 38, 223–36.

Pearlin, L.I., Lieberman, M.A, Menaghan, E.G and Mullan J.T (1981) ‘The Stress Process’, Journal of Health and Social Behavior 22, 337–56.

Pearlin. L.I. (1989). “The Sociological Study of Stress”. *Journal of Health and Social Behaviour*. Vol 30: 241-256.

Pezaro, S. (2018). “Securing the Evidence and Theory-based Design of an Online Intervention Designed to Support Midwives in Work-related Psychological Distress”. *Journal of the International Society for Telemedicine and EHealth*, *6*(1), e8 (1-12).

Pope C, Ziebland S., and Mays N. (2000). Qualitative research in health care. Analysing qualitative data. 8;320(7227):114-6. doi: 10.1136/bmj.320.7227.114. PMID: 10625273; PMCID: PMC1117368

Preckel, K., Trautman, S., and Kanske, P. (2021). Medication-Enhanced Psychotherapy for Post-Traumatic Stress Disorder: Recent Findings on Oxytocin's Involvement in the Neurobiology and Treatment of Post-Traumatic Stress Disorder. *Clinical Psychology in Europe* 2021, Vol. 3(4), Article e3645, https://doi.org/10.32872/cpe.3645.

Prem, R., Ohly, S., Kubicek, B., and Korunka, C. (2017) "Thriving on Challenge Stressors? Exploring Time Pressure and Learning Demands as Antecedents of Thriving at Work". *Journal of Organizational Behavior* 38 (1), 108-123

Rafferty AM, Clarke SP, Coles J, Ball J, James P, McKee M, Aiken LH (2007). "Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional analysis of survey data and discharge records". *International Journal of Nursing Studies*. 44(2), 175-182.

Rapley, T. (2004) 'Interviews', in Seale, C., Gobo, G., Gubrium, J. F. and Silverman, D.(eds) Qualitative Research Practice. London: Sage, pp. 15-33.

Rapley, T. (2004). Interview. In C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman (Eds.), *Qualitative Research Practice*. London: Sage Publications.

Ravalier, J.M., McVicar, A., and Boichat, C. (2020). "Work stress in NHS employees: a mixed-method study. *International Journal of Environmental Research and Public Health* Sep 2020; 17(18): 6464. Doi: 10.3390/ijerph17186464.

Reininghaus, U., Jamieson-Craig, T., Gournay, K., Hopkinson, P., and Carson, J. (2007). "The high secure psychiatric hospitals' nursing staff stress survey 3: Identifying stress resistance resources in the stress process of physical assault". *Personality and Individual Differences,* Vol. 42(3), 397–408.

Reissner SC and Whittle A (2021) Interview-based research in management and organisation studies: Making sense of the plurality of methodological practices and presentational styles, *Qualitative Research in Organizations & Management*, early cite (DOI: 10.1108/QROM-03-2021-2118).

Reissner, S.C. (2018). “Interactional challenges and researcher reflexivity: Mapping and analysing conversational space”. *The Journal of The European Academy of Management.* https://doi.org/10.1111/emre.12111.

Reissner, S.C. and Whittle, A. (2021). “Interview-based research in management and organisation studies: Making sense of the plurality of methodological practices and presentational styles”, *Qualitative Research in Organizations and Management*, early cite (DOI: 10.1108/QROM-03-2021-2118).

Reissner, S.C., Izak, M., and Hislop, D. (2021) “Configurations of boundary management practices among knowledge workers”. *Work, Employment and Society*, 35(2), 296–315.

Remenyi, D., Williams, B., Money, A. and Swartz, E. (1998) *Doing research in business and management: an introduction to process and method.* Sage, pp320. ISBN 9780761959502

Rheaume, A., Mullen, J. (2017). “The impact of long hours and shift work on cognitive errors in nurses”. *Journal of Nursing Management,* Vol. 26(1), 26–32.

Rimmer A (2018). Staff stress levels reflect rising pressure on NHS, says NHS leaders. *BMJ.* 2018; 360:k1074.doi: 10.1136/bmj.k1074. PubMed

Ritchie, J. and Spencer, L. (1994) 'Qualitative data analysis for applied policy research', in Bryman, A. and Burgess, R. (eds). Analysing Qualitative Data. London: Routledge.

Roche, M.A., and Duffield, C. (2010). “A Comparison of the Nursing Practice Environment in Mental Health and Medical-Surgical Settings”. Journal of Nursing Scholarships. 42(2).:195-206. DOI:10.1111/j.1547-5069.2010.01348.x.

Rolewicz, L., and Palmer, B. (2019). The NHS workforce in numbers. Facts on staffing and staff shortages in England. Available at: www.nuffieldtrust.org.uk. (Accessed 11th August 2020).

Ross, F. (2018). *Stress vs Anxiety – Knowing the Difference is Critical To your Health*. Mental Health First Aid.

Ross, S., and Naylor. (2017). Quality improvement in mental health. Available at: www.kingsfund.org.uk. (Accessed 1st June 2021).

Rossler, W. (2012). “Stress, burnout, and job dissatisfaction in mental health workers”. *European Archives of Psychiatry and Clinical Neuroscience*. Vol. 262(2), 65–69.

Roulston, K (2010). *Reflective Interviewing: A Guide to Theory and Practice* London: SAGE Publications Ltd.

Ruotsalainen, J.H., Serra, C., Marine, A., and Verbeek, J.H. (2015). “Preventing occupational stress in health care workers”. *Cochrane Database for Systematic Reviews,* 2015(4), DOI: 10.1002/14651858.CD002892.pub5.

Russo, S., Ronchetti, M., Di Tecco, C., Valenti, A., Jain A., Mennini, FS. Leka, S., and Lavicoli, S. (2021). “Developing a cost-estimation model for work-related stress: An absence-based estimation using data from two Italian case studies”. *Scandinavian Journal Work Environment and Health*. 1; 47(4):318-327. Doi: 10.5271/sjweh.3948. PMID: 33595090; PMCID: PMC8091069.

Sakellariou, D., Rotarou, E.S. (2017). The effects of neoliberal policies on access to healthcare for people with disabilities. *International Journal of Equity Health* 16, 199 https://doi.org/10.1186/s12939-017-0699-3.

Saunders, J. (2016). "Ideology and work in the Early NHS". *People’s History of the NHS*. Cultural History of the NHS Project.

Saunders, M., Lewis, P. and Thornhill, A. (2009) *Research Methods for Business Students*, 5th Edition, Harlow, Essex: Pearson Education Limited.

Saunders, M., Lewis, P., and Thornhill, A. (2016). *Research Methods for Business Students*. 7th Edition, London: Pearson Education.

Saunders, M.N.K., and Townsend K. (2016). “Reporting and Justifying the Number of Interview Participants in Organisation and Workplace Research”. *British Journal of Management*. 27(4). 836-852.

Savickas, M L, Nota, L, Rossier, J, Dauwalder, J-P et al. (2009) ‘Life Designing: A paradigm for career construction in the 21st century’ *Journal of Vocational Behaviour* 75(2009) 239-250

Schaufeli, W.B., and Bakker. (2004). “Job demands, job resources and their relationship with burnout and engagement: a multi-sample study”. *Journal of Organisational Behaviour*. 25, 293- 315 (2004). DOI: 10.1002/job.248.

Schwandt, T. (1997) Qualitative Enquiry: A Dictionary of Terms. Thousand Oaks, CA: Sage.

Schwartzman, H. (1993). Ethnography in Organisations. London: SAGE

Sedigh, G., Devlin, R.A., and Grenier, G. (2017). “Are Quebecers more stressed out at work than others? An investigation into the differences between Quebec and the rest of Canada in level of work stress." *Canadian Public Policy*. Vol. 43(3): 177–189

Selye H. (1976). *The Stress of Life.* Rev. edn. New York: McGraw-Hill.

Selye, H. (1983). The concept of stress: Past, present and future. In C.L. Cooper (Ed.). *Stress research: Issues for the eighties.* New York: John Wiley.

Siegrist, J. (1996), “Adverse health effects of high effort/low reward conditions”, *Journal of Occupational Psychology*, Vol. 1(1), 27–41.

Silverman, D (2013a). *Doing Qualitative Research: A Practical Handbook* 4th Edition London: SAGE Publications Ltd.

Silverman, D (2014). *Interpreting Qualitative Data* 5th Edition London: SAGE Publications Ltd

Silverman, D. (2005) Doing Qualitative Research: A Practical Handbook. (2nd ed) London: Sage.

Silverman, D. (2010). *Doing Qualitative Research*: A Practical Handbook. (3rd ed) London: Sage

Smith, J. A. and Osborn, M. (2008) 'Interpretive phenomenological analysis', in Smith, J. A.(ed), *Qualitative Psychology*: A Practical Guide to Research Methods. (2 ed) London: Sage.

Smollan, R. K. (2017). "Supporting staff through stressful organizational change." *Human Resource Development International*, Vol 20, 282-304.

Smyth, J., Zawadzki, M., and Gerin, W. (2013). “Stress and disease: A structural and functional analysis. *Social and Personality Psychology Compass*, 7, 217–227. https://doi.org/10.1111/spc3.12020

Snape, D. and Spencer, L. (2003) 'The Foundations of Qualitative Research', in Ritchie, J. and Spencer, L.(eds) *Qualitative Research Practice*. London: Sage, pp. 1-22.

Spencer, L., Ritchie, J. and O'Conner, W. (2003) 'Carrying out Qualitative Analysis', in Ritchie, J. and Lewis, J. (eds) Qualitative Research Practice. London: Sage, pp. 219-262.

Stansfeld, S.A., Rael, E., Head, J., Shipley, M.J., and Marmot, M.G. (1997). “Social support and psychiatric sickness absence: a prospective study of British civil servants”. *Psychological Medicine*, Vol. 27, 35–48.

Starman, A.B. (2013). The case study as a type of qualitative research. Journal of Contemporary Educational Studies. 1 (2013), 28-34.

Stevenson, D., and Farmer, P. (2017) *Thriving at Work: The Independent Review of Mental Health and Employers*. DWP.

Sugimura, H. and G. Theriault (2010). "Impact of Supervisor support on work ability in an IT company." *Occupational medicine*, Vol 60: 451-457.

Sutherland, V., and Cooper, C.L. (1990). *Understanding Stress: A Psychological Perspective for Health Professionals*. London: Chapman and Hall.

Teherani, A., Martimianakis, T., Stenfos-Hayes, T., et al. (2015). “Choosing a qualitative research approach”. *Journal of Graduate Medical Education*. Vol. 7(4), 669–670.

Tetrick, L.E., and Winslow, C.J. (2015). ‘Workplace stress management interventions and health promotion’. *Annual Review of Organisational Psychology and Organisational Behaviour*. 2 (1), 583-603.

The Kings Fund (2017). The evolving NHS. Available at: https://www.kingsfund.org.uk. (Accessed 10th July 2021).

Thornley, C. (2000). “A question of competence? Re-evaluating the roles of the nursing auxiliary and health care assistants in the NHS”. *International Journal of Clinical Nursing,* Vol. 9(3), 451–458.

Tocino-Smith, J. (2019). “What is Eustress? A look at the Psychology and Benefits”. *Stress and Burnout Prevention*.

Tully, A. (2004), “Stress, sources of stress and ways of coping among psychiatric nursing students”. *Journal of Psychiatric and Mental Health Nursing.* https://doi.org/10.1111/j.1365-2850.2004.00683.x.

UKRI (2021). Framework for research ethics. Available at: https://www.ukri.org. (Accessed 2nd June 2021).

Van den Berg, T. I., et al. (2008). "The influence of psychosocial factors at work and lifestyle on health and work ability among professional workers". *International Archives of Occupational and Environmental Health*, Vol. 81(8), 1029–1036.

Van der Doef, M., and Maes, S. (2010). "The Job Demand-Control (-Support) Model and psychological wellbeing: A review of 20 years of empirical research". *International of Work, Health and Organisation,* Vol. 13(2), 87–114.

Van der Schaaf, P.S., Dussildorp, E., Keuning, F.M., et al. (2013). "Impact of the physical environment of psychiatric wards on the use of seclusion". *British Journal of Psychiatry.* Vol. 202(2), 142–149.

Van Manen, M (1990) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* Albany, New York: The State University of New York Press.

Vos, T., et al. (2013) 'Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study'. *The Lancet.* 386 (9995). 743-800.

Walonick, D.S. (1993). *"Causes and Cures of Stress in Organisations".* California: McGraw-Hill: 707-710. Hylen, U., Kjellin, L., Pelto-Piri, V., and Warg, (2018). "Psychosocial work environment within psychiatric inpatient care in Sweden: Violence, stress and value incongruence among nursing staff". *International Journal of Mental Health Nursing*. 27(3), 1086-1098.

Waring, J. and G. Currie. 2009. 'Managing Expert Knowledge: Organizational Challenges and Managerial Futures for the UK Medical Profession', Organization Studies, 30, 7, 755-78.

Watson, G. and Reissner, S.C. (2022). *Developing Skills for Business Leadership*, 3rd Edition, London: Kogan Page.

Watson, T J and Watson, D H (2012) 'Narratives in society, organizations and individual identities: An ethnographic study of pubs, identity work and the pursuit of 'the real' *Human Relations* 65(6) 683-704.

Webber, A. (2020). NHS staff survey reveals little progress in boosting health and wellbeing. *Occupational Health and Wellbeing Plus.* Available at: https://www.personneltoday.com.

Weber, M. (1978). *Economy and Society*. London: University of California Press.

WHO (2012). WHO Mental Health PHC Integration Checklist.

Wilberforce, M., Abendstern, M., Tucker S, Ahmed, S., Jasper, R., and Challis D (2017). "Support workers in community mental health teams for older people: roles, boundaries, supervision and training". *Journal of Advanced Nursing.* 73(7):1657-1666.

Williams, A.M., and Williams, N.J. (2022). "Using a cognitive framework with nurses to manage stress. Journal of Evaluation in Clinical Practice. https://doi.org/10.1111/jep.13763.

World Health Organisation (2005) Promoting Mental Health: Mental health and substance abuse. Available at: http://www.who.int/topics/mental_health/en/ (Accessed 16th June 2019).

World Health Organisation (2009) Ten Facts about Mental Health. Available at: http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/index.html (Accessed: 16th June 2019).

World Health Organisation (2012). "WHO and wellbeing". *Wellbeing at Work* 2012. 21-23 May 2012.

World Health Organization (2013). *Ottawa charter for health promotion.* Geneva: World Health Organisation. (Accessed: 10th July 2020).

Wosu, A.C., Valdimarsdóttir, U., and Shields, A.E., et al. (2013), "Correlates of cortisol in human hair: Implications for epidemiologic studies on health effects of chronic stress", *Annals of Epidemiology*, Vol. 23(2), 797–811.

Wright Mills, C (2000). *The Sociological Imagination Fortieth Anniversary Edition* New York, New York: Oxford University Press, Inc.

Zaleznik, A., Kets de Vries, M., and Howard, J. (1977). "Stress Reaction in Organizations: Syndromes, Causes and Consequences", *Behavioural Science*, Vol 22 (1)151-162.

Zawadzki, M., Hussain, M., and Kho, C. (2022). “Comparing multidimensional facets of stress with social, emotional, and physical well-being using ecological momentary assessment among a Hispanic sample”. *Stress and Health*. Vol. 38(2), 375–387.

APPENDX 1- DEBRIEFING SHEET/EMAIL TEMPLATE

Causes of stress leave among NHS Mental Health Support Workers

Debriefing sheet/Email Template

Dear {name}

Thank you very much for participating in an interview {date, time, location} as part of my research on the causes of stress leave among mental health workers. I appreciate your help in answering the questions of what causes stress leave for staff and what could be done to reduce the need for it.

Attached is a copy of the interview transcript to check and amend where necessary, to ensure that it is a true record of our conversation before I start analysing the data.

Participation in the research is voluntary and it is fine to change your mind. I will appreciate it though if you could let me know within the next two weeks whether I could use the content of the interview for analysis. If I do not hear from you by {date two weeks in advance}, I will assume that you are happy for me to start analysing the data. You can receive a copy of the report summarising initial findings in about {expected date} by email if you wish; in this case, please confirm your email address and also let me know if you want to be kept informed about the research.

Again, thank you very much for your participation in this interview.

Kind Regards,

Rita Ojeme

PhD student, Newcastle University

R.E.Ojeme2@newcastle.ac.uk.

APPENDIX II - DEBRIEFING SHEET 2

Causes of stress leave among NHS Mental Health Support Workers

Debriefing sheet

Dear {name}

Thank you for participating in an interview as part of my research on the causes of stress leave among mental health workers. I appreciate your help in answering the questions of what causes stress leave for staff and what could be done to reduce the need for it. I hope that you have found the interview an interesting and enjoyable experience, if not below are the contact details of "Team Prevent" who are happy to offer any emotional support that you may need.

I will email you a copy of the interview transcript to check and amend where necessary, to ensure that it is a true record of our conversation before I start analysing the data. If you want to be kept informed about the research, please confirm your email address and I will be happy to send you a report.

Again, thank you very much for your participation in this interview.

Team prevent,

The Grainger Suite, Dobson House,

Regent Centre, Regent Farm Road,

NE3 3PF,

Newcastle.

Telephone: 01327810271.

Best regards,

Rita Ojeme

PhD student, Newcastle University

R.E.Ojeme2@newcastle.ac.uk.

APPENDIX III - INFORMATION SHEET

INFORMATION SHEET

Dear prospective research participant: I am writing to invite you to participate in my doctoral research on causes of stress leave among mental health workers in the NHS. Please read this information sheet carefully and ask as many questions as you like before you decide whether you want to participate in this research. You are free to ask questions that would help your decision as to whether you wish to take part or not.

Project Title: Causes of stress leave amongst mental health workers in the NHS.

Principal Investigator: Rita Ojeme. Email: R.E.Ojeme2@newcastle.ac.uk .

Location: NHS Trust Site

PURPOSE OF THIS RESEARCH STUDY

You are being asked to participate in a research designed to examine stress leave amongst mental health workers considering its causes, manifestations and organizational ways of dealing with it. Workplace stress is on the increase and different occupations have their different stressors that is intrinsic to the nature of the job.

PROCEDURES

Participants have been invited to participate in this research to help provide answers to the question of what causes stress among mental health workers. It is hoped that the study will help the NHS to provide a less stressful working environment for staff. This research will involve interviews and observations to collect data. The interview should not take any longer than 60mins and will be conducted in a room allowing for privacy on your organization's premises. The topics that will be discussed during the interview include the causes of stress in the workplace, how occupational stress can be managed by individuals, managers and the organisation and what policies can be adopted to help reduce stress at work. These topics may be stressful to you, in this case, "Team Prevent" whose contact details you will find below are happy to provide any emotional support that you may need. The interviews and supporting notes from observations will be audio-recorded and transcribed by the researcher and no names or other identifying information would be elicited and used in the recordings and transcripts. You will receive a copy of the transcript which you will be able to review and comment your responses and I will attempt to contact you when the data have been destroyed.

ETHICS/CONFIDENTIALITY

Participation in this research is entirely voluntary. Access to staff record is not required. Any personal information/data collected will remain confidential and any quotes used in any publication will be anonymized to protect your identity. Only the researcher will have access to the personal information/data which will be stored in a secure university server for approximately five years which includes the duration of the PhD and publication. I will report the findings to your employer, but no such report will include any names or any other identifying details that could be linked to you. At the end of the study, I will provide you with a summary of the main findings.

TERMINATION OF RESEARCH STUDY

You are free to choose whether or not to participate in this study. You can choose to cease participation at any time prior to publication of findings.

I hope that you will have found the interview an interesting experience.

Below are the contact details of "Team Prevent"

Team prevent,

The Grainger Suite, Dobson House,

Regent Centre, Regent Farm Road,

NE3 3PF,

Newcastle.

Telephone: 01327810271.

AVAILABLE SOURCES OF INFORMATION

Any further questions you have about this study will be answered by the researcher listed above.

Any concerns can be discussed with the research supervisors:

Name: Professor Tom McGovern

Email: tom.mcgovern@newcastle.ac.uk.

Name: Dr. Stefanie Reissner

Email: Stefanie.reissner@newcastle.ac.uk.

APPENDIX IV- INFORMED CONSENT

Informed consent form for persons participating in research projects

Project Title: Causes of stress leave among NHS Mental Health Workers

Researcher: Rita Ojeme

Name of supervisors: Professor Tom McGovern and Dr. Stefanie Reissner

	Y	N
I give consent for myself to participate in this research	[]	[]
I received an information sheet about this research	[]	[]
I voluntarily agree to participate in this research	[]	[]
The procedures regarding anonymity have been explained to me	[]	[]
I understand that the purpose of the study is for doctoral research	[]	[]
I understand that I can withdraw from the study at any time	[]	[]
I understand that only the researcher will have access to the data	[]	[]
The use of data in research and publication as well as storage has been explained to me	[]	[]
I, along with the researcher wish to sign and date this form	[]	[]

Participant:

Signature_____________________________________ Date______________________________________

Name of Participant

Researcher:

Signature______________________________________ Date_____________________________________

Name of Researcher

APPENDIX V- FULL ETHICAL REVIEW FORM

Full Ethical Review Form

(Version 2.1)

Section 1: **Applicant Details**

Mandatory Section

Applicant Name	*RITA OJEME*
Contact Email	*R.E.Ojeme2@newcastle.ac.uk*
Academic Unit	*Newcastle University Business School*
Project Type	*Student Project*

Additional details for non-staff projects

Type of Degree Programme	*Postgraduate Research (e.g. PhD)* *PhD*
Module Code	
Supervisors Email	*tom.mcgovern@newcastle.ac.uk; Stefanie.reissner@newcastle.ac.uk.*
Supervisors Academic Unit	*Newcastle University Business School*

Section 2: **Project Details**

Mandatory Section

Project Title	*Causes of stress leave amongst NHS Mental Health Workers*

Project Synopsis	NHS data show that stress leave is very high and work-related stress is widespread among NHS staff. Recently, according to the NHS staff survey, nearly 40% of staff reported feeling unwell as a result of stress in the workplace (West 2016). In effect, NHS staff are more likely than the rest of the working population to become patients, thereby increasing the demands in the system they work in. Research has shown that the most important factor contributing to work stress is lack of clear roles, lack of resources, having to deal with patients, conflict, and overload, with staff simply asked to manage too much work (West 2016). The aim of this research is to examine stress leave amongst mental health workers considering its causes, manifestations and organisational issues. It is hoped that the study will contribute to the development of policy and practice to provide a less stressful working environment and a concomitant reduction in stress leave. It is expected to create a better understanding of the causes of stress among healthcare workers and to develop a framework for dealing with stress at work.
Project Start Date	25/09/2017
Project End Date	25/09/2020
High Risk Flags from Preliminary	'NHS'
My Projects Reference	
Project Funder Details	Primary: Secondary: Tertiary:
External Collaborators	

Section 3: **Existing Ethics, Sponsorship & Responsibility**

Mandatory Section

Ethical Approval in place	No
Ethical Approval accepted by faculty	N/A
No of Approvals uploaded	
Approving Body Details:	Name: Reference: Date of Approval:
NHS Research Sponsor name	
NUTH Reference	
External responsibility for Project Conduct, Management & Design	Conduct: , , , () Management: , , , () Design: , , , ()

Section 4: Project Outline & Proposed Research Methods

Mandatory Section

4.1 Project Outline and Aims

In everyday language, briefly explain the aims of this research including the anticipated benefits and risk. In cases where the use of technical or discipline specific terms is unavoidable please explain their meaning clearly.	The aim of this research is to examine stress leave among mental health workers considering its causes, manifestations and organisational issues. It is hoped that the study helps to provide a less stressful working environment and a concomitant reduction in stress leave. It is also expected to create a better understanding of the causes of stress among healthcare workers and to develop a framework for dealing with stress at work.

4.2 Proposed Research Method (Experimental Design)

In everyday language, please provide an outline of the research methods in a clear step by step chronological order. Noting any pertinent information such as whether the research involves overseas partners and how you will handle the research data.	This study is qualitative in nature and seeks to draw a broad set of data in order to examine the causes of stress leave amongst mental health workers in a single NHS Trust. As such, multiple data collection methods such as qualitative interviews, and field notes will be used to collect data for this research. With the Trust's permission, frontline managers-, and key staff such as mental health support workers, HR representatives and occupational health specialists will be interviewed. This will be done face – to –face where possible within the Trust. The researcher works part-time in the Trust and will capture her observations while at work in ethnographic-style field notes i.e. Ethnographic immersion will be used where a researcher will keep a note and record thoughts, observations and feelings while at work. The data will be analysed inductively using a thematic approach (King 2004).

Section 5: Animals

Only completed if animals risk identified

5.1 Home Office License

Is the work covered by an existing Home Office license?	N/A
Reference:	0
Do you intend to apply for a Home Office License?	0
Has the Comparative Biology Centre been consulted?	0
Has the Home Office been consulted?	0

If your project involves wild caught animals, are permissions in place?	0

5.2 Why is the use of animals necessary in this project?	0

5.3 What kinds of animals will be used and how many of each?	N/A

5.4 What will happen to the animals during and after the project?	N/A

5.5 Who will be carrying out the project? Briefly describe the relevant experience and expertise of the persons involved?	N/A

5.6 Where will the animals be housed/located? If the animals are being observed in the wild or in establishments such as zoos, has permission been obtained from the appropriate authority? For any work outside the UK, do the standards of animal care and accommodation comply with UK codes of practice? If not explain how they differ.	N/A

5.7 What checks will be made on the animals, how frequently and by whom? What actions will be taken in the event of any adverse effects on the animals?	N/A

Section 6: **Humans in a Non-Clinical Setting**

Only completed if humans non-clinical risk identified

6.1 Does the research specifically target / involve participants who are:

Adults (over 18 years old and competent to give consent)	Yes
Children / Legal minors (anyone under 18 years old)	No
People from non-English speaking backgrounds	No
Persons incapable of giving consent	No
Prisoners or parolees	No
Recruited through a gatekeeper	Yes
Welfare recipients	No
How many participants do you plan to recruit?	Up to a 100 Participants

6. 2 From which source and, by what means do you plan to recruit your participants?	Participants will be recruited from a single NHS Trust. Access to participants and ethics requirement have been discussed with authoritative staff from the Trust who are in support of my research. The Trust research executive also advised that since the research is taking place in a single Trust and involving only staff as participants, automatic approval of the research will be granted by the Trust following approval by Newcastle University without need of approval from REC.

6.3 Participant Information

Will you inform participants that their participation is voluntary?	Yes
Will you inform participants that they may withdraw from the research at any time and for any reason?]	Yes
Will you inform participants that their data will be treated with full confidentiality and, if published, it will not be identifiable as theirs?	Yes
Will you provide an information sheet which includes the contact details of the researcher / research team?	Yes

Will you obtain written consent for participation?	Yes
Will you debrief participants at the end of their participation (i.e. give them an explanation of the study aims and hypotheses)?	Yes
Will you provide participants with a written debriefing too?	Yes, a two-stage process has been devised. In stage 1, directly after the research interview, research participants will receive a hard-copy debriefing sheet containing the contact details of Team Prevent, a confidential service provided by the Trust, in case emotional support is required. In stage 2, a standard email will be sent accompanying the interview transcript further reiterating the purpose of this research. Sample texts are submitted with this form.
If you are using a questionnaire, will you give participants the option of omitting questions that they do not want to answer?	N/A
If your work is experimentally based, will you describe the main experimental procedures to the participants in advance so that they are informed about what to expect?	N/A
If the research is observational, will you ask participants for their consent to being observed?	No

6.4 Participant Consent

Please describe the arrangements you are making to inform potential participants, before providing consent, of what is involved in participating in your study and the use of any identifiable data, and whether you have any reasons for withholding particular information. Due consideration must be given to the possibility that the provision of financial or other incentives may impair participants ability to consent voluntarily.	Potential participants will be invited to participate in the research by email via a nominated contact within the Trust. It is envisaged that this email will contain the information sheet and consent form (examples are submitted with this form). Staff willing to participate in this research will be asked to contact the researcher for further details and to schedule interviews at a mutually agreed time, date and place. The interviews are most likely to be conducted during working hours on a Trust site to ensure safety of both researcher and participant. The research methodology requires interview with participants therefore no information regarding the research will be withheld from participants and no incentives will be provided for participating in the interview.

Participants should be able to provide written consent. Please describe the arrangements you are making for participants to provide their full consent before data collection begins. If you think gaining consent in this way is inappropriate for your project, please explain how consent will be obtained and recorded. (A copy of your consent form must be provided with your submitted application)	Potential research participants will receive a copy of the information sheet and consent form in an initial communication with a request to read and complete the forms. At the beginning of the interview, the researcher will ascertain that research participants have understood the purpose of the research as well as their role and their rights and give them a further opportunity to ask questions. The researcher will also ensure that a signed copy of the consent form is received prior to the interview where possible.

6.5 Participant Debriefing

It is a researcher's obligation to ensure that all participants are fully informed of the aims and methodology of the project, that they feel respected and appreciated after they leave the study, and that they do not experience significant levels of stress, discomfort, or unease in relation to the research project. Please describe whether, when, and how participants will be debriefed. (A copy of your debriefing sheet must be provided with your submitted application)	At the end of interview, the researcher will reiterate the purpose of the research and any further process. Within one week after data collection, participants will receive an email thanking them for their participation that includes a copy of the interview transcript and a statement reiterating the purpose of the research, participant's role and rights as well as the researchers contact details (see example attached to this application). The researcher will also send participants a copy of a report of findings to be submitted to the participating organisation if they wish.

6.6 Potential risk to participants and risk management procedures

Identify, as far as possible, all potential risks (small and large) to participants (e.g. physical, psychological, etc.) that may be associated with the proposed research. Please explain any risk management procedures that will be put in place and attach any relevant documents in the section below. Please answer as fully as possible.	The main risk here is anticipated to be an emotional vulnerability among research participants as a result of stress which might be exacerbated by participating in the interview. The researcher has confirmed that the Trust has adequate support mechanism for any staff who may feel distressed after the interview. The Trust's "Team Prevent", an occupational health and wellbeing team provide full employee health and wellbeing support service for staff and are always on standby to provide support and guidance should any staff need it during the process of this research. Their specialist practitioners have confirmed they will be pleased to help where they can.

Supporting Documents attached	Information sheet, debriefing information and consent form.

Section 7: **Data**

Mandatory Section

7.1 Please describe how data will be accessed, how participant's confidentiality will be protected and any other relevant considerations. Information must be provided on the full data lifecycle, from collection to archive.	Data will be generated mostly in personal interaction between the researcher and participants, through interviews. Interviews will be recorded digitally (mp3) if research participants consent otherwise very detailed notes will be made. The interview recordings and supporting notes will be transcribed and anonymised as outlined in the consent process. The anonymization code will be stored separately to the interview data and be password protected. Participants will be emailed a copy of the interview transcript to check out and amend where appropriate. By so doing, participants will be able to exclude any text they wish from the data analysis. In any publications such as reports to the participating organisations, findings will be produced in an abstract and anonymized form. Specifically, the organisation's and participant's names and any identifying details will be anonymised (e.g. through a pseudonym) or removed to protect their identity. There are no requirements to make the data publicly available which means that the data will not be shared with any third parties. All digital data including master copies will be securely stored on a password protected laptop and backed up on an encrypted external drive. The data will be kept for six years which includes the duration of the doctoral study plus the required period of writing journal articles. The data will then be destroyed using DBAN (Darik's Boot and Nuke) software.

Supporting Documents attached	Information sheet and consent form and debriefing information.

Section 8: **Environment**

Only completed if environmental risk identified

8.1 Please provide the locations in which your research will take place, together with the anticipated risks (emissions, destruction of habitat or damage to artefacts etc.), potential damage and mitigating measures planned.	N/A

Section 9: **International (non EEA)**

Only completed if international risk identified

9.1 For any research conducted outside the European Economic Area (EEA) the researcher is responsible for ensuring that local ethical considerations are complied with and that the relevant permissions are sought. Please state the location(s) in which your research will take place?	N/A
9.2 Have the appropriate local ethical considerations been complied with and relevant permissions sought?	N/A

Section 10: **Permissions**

Mandatory Section

Please use the table to record details of any licenses or permissions required and / or applied for e.g. Local Authority District, Natural England etc. Ensure you include the reference, status and the date it was granted (if applicable).	1.Permission / License: , Awarding Body: , Reference: , Date: , Status: 2.Permission / License: , Awarding Body: , Reference: , Date: , Status: 3.Permission / License: , Awarding Body: , Reference: , Date: , Status: 4.Permission / License: , Awarding Body: , Reference: , Date: , Status: 5.Permission / License: , Awarding Body: , Reference: , Date: , Status:
Supporting Documents attached	0

Section 11: **Risk Considerations and Insurance**

Mandatory Section

11.1 What are the potential risks to the researchers themselves? This may include: personal safety issues, such as those related to lone working, out of normal hours working or to visiting participants in their homes; travel arrangements, including overseas travel; and working in unfamiliar environments. Please explain any risk management procedures that will be put in place and note whether you will be providing any risk	The researcher does not envisage any potential risks to herself during the research. The site where the research will be conducted is local and familiar to the researcher. Also, the research is going to take place during office hours in a corporate location. The researcher will also have her mobile phone with her and inform relatives of her whereabouts.

assessments or other supporting documents.	

Supporting Documents attached	

Section 12: **Human Tissues**

Only completed if Human Tissue's are being used

Does your study involve “relevant materials” as defined by the Human Tissue Act (2004)*?	N/A
Will you be storing the material for more than 7 days prior to either: processing the material to remove the cellular component, or transferring the material elsewhere (to non-Newcastle University premises)?	N/A
Have you agreed a storage location with the Designated Individual?	N/A
Location	

Section 13: **Supporting Documentation (not uploaded elsewhere)**

Non-Mandatory Section

Supporting Documents attached	

Section 14: **Admin Section**

Non-Mandatory Section

LimeSurvey Response ID	2584
Date Completed	08/12/2017 11:26
Number of Documents uploaded	0
Appropriate Review Committee	NHS

APPENDIX VI - CLARIFICATION ABOUT THE USE OF OBSERVATION AND ETHNOGRAPHIC-STYLE FIELD NOTES

Clarification about the use of observation and ethnographic-style field notes.

Newcastle University

Faculty of Humanities and Social Sciences Ethics Committee

Review of Application for Ethical Approval

Researcher: Rita Ojeme

Title: Causes of stress leave among mental health workers in the NHS

Date: 16.4.2018

Ethics reviewer: Christos Salis

Thank you for submitting your application for ethics review. Please consider the points identified below, discuss them with your supervisors and respond with a brief comment into this document (as indicated). Return the document to me along with any amended research documentation. Please do not hesitate to contact me should anything require clarification or further discussion.

Clarification about the use of observation and ethnographic-style field notes:

Please provide more information about this aspect of the project, and, in particular, if such observations will involve clinical NHS staff and their interactions with patients and their relatives or carers. Please also clarify if field notes would involve covert observation that will not be disclosed to prospective participants.

Revisions to the Information Sheet:

1. Please add the word “doctoral” (or “PhD”) in the first line of the Information Sheet so that it reads “… in my doctoral research …”.
2. Please provide a brief statement as to why participants have been invited to take part in the project. This could be included in the first paragraph or in the procedures section.

3. Please provide additional information about the topics that will be discussed during the interviews.
4. It is important to include information about the potential for distress and reference to Team Prevent in the information sheet (as well as the Debriefing Sheet, as currently present).

Research & Development approval:

This point does require a response but it is only provided for consideration. While ethical review from a NHS Research Ethics Committee is not required (according to the decision-making framework of NHS Health Research Authority (link below), however, it would be advisable to find out if the Trust's Research & Development approval would be required before the study commences.

https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/

Clarification about the use of observation and ethnographic-style field notes:

I will not be using participant observations for this research because participant observations is typically associated with specific meetings and events whereas what I am planning to do is an ethnographic immersion consisting with a diary to note observations and reflections at work.

Thus, observations will not involve clinical staff and their interactions with patients or relatives rather ethnographic field notes will allow me to formally record during my shift, my reflections of what is happening among frontline staff. Field notes will involve covert observations but can be disclosed to prospective participants should they require it.

Research & Development approval:

Yes the Trust's Research & Development approval is required before data collection can commence and they are happy to grant this once ethics approval has been granted by the school.

APPENDIX VII- RESEARCH PROTOCOL 1

RESEARCH PROTOCOL

CAUSES OF STRESS LEAVE AMONG NHS MENTAL HEALTH WORKERS.

Principal Investigator: Rita Ojeme

Supervisors: Professor Tom McGovern

Dr. Stefanie Reissner

Set of research questions

The aim of the research is to examine stress and sickness absence among mental health workers in the NHS considering its causes, manifestations and associated organisational issues, such as the institutional support mechanisms to address and reduce stress among its staff. In order to achieve this aim, the following research questions need to be addressed:

1. What are the causes of stress among mental health support workers?
2. To what extent can organisational stress be managed by individuals, managers and the organisation?
3. What policies can be adopted by the National Health Service to reduce stress at work amongst mental health workers?

Rationale for Research

The knowledge of occupational stress, its sources, causes and effects is very important with regards to policy development in coping strategies and managing the condition (Ashong et al 2016). In addition, preventing and reducing sickness absence as a result of stress is challenging and new measures are needed to tackle this issue (Holmgren 2016).

Also from an empirical point of view as a mental health support worker, I have observed colleagues going on sick leave regularly due to stress especially on instances when the ward gets very busy. For example, if there were new admissions of very challenging patients, they sometimes make the ward unbearable for staff to work. Additionally, due to the nature of the ward and the work environment which most times is deemed as aggressive which has an effect

on control for both staff and patients (Van der, 2013), colleagues are eager to change wards as they feel some wards are sometimes less stressful to work in than others.

Methodology

Research Philosophy

The ontological and epistemological positions of this research is Interpretivism. An inductive approach will be adopted wherein theories and concepts will be developed from data.

Method

The study is qualitative, ethnographic and involving a single case in an NHS Trust. The case study will be descriptive, exploratory and based on an inductive approach (Saunders et al, 2016).

Data collection Protocol

The study will also use three main methods of data collection namely:

1. Face to face interviews: - with the Trust's permission, mental health support workers, their line managers and key staff such as HR representatives and occupational health specialists will be interviewed (these are my main participants and I am aiming at 30-40 interviews).

2. Organisational documents such as policies and procedures etc. will be analysed.

3. Ethnographic field notes will allow me to formally record my reflections after my shifts of what is happening among staff.

APPENDIX VIII- RESEARCH PROTOCOL 2

RESEARCH PROTOCOL

CAUSES OF STRESS LEAVE AMONG NHS MENTAL HEALTH WORKERS.

Principal Investigator: Rita Ojeme

Supervisors: Professor Tom McGovern

Dr. Stefanie Reissner

Set of research questions

The aim of the research is to examine stress and sickness absence among mental health workers in the NHS considering its causes, manifestations and associated organisational issues, such as the institutional support mechanisms to address and reduce stress among its staff. In order to achieve this aim, the following research questions need to be addressed:

1. What are the causes of stress among mental health support workers?

2. To what extent can organisational stress be managed by individuals, managers and the organisation?

3. What policies can be adopted by the National Health Service to reduce stress at work amongst mental health workers?

Data collection Protocol

The study will also use three main methods of data collection namely:

1 Face to face interviews- with the Trust's permission, mental health support workers, their line managers and key staff such as HR representatives and occupational health specialists will be interviewed (these are my main participants and I am aiming at 30-40 interviews).

2 Organisational documents such as sickness figures, policies and procedures etc. will be analysed.

3 Ethnographic field notes will allow me to formally record my reflections after my shifts of what is happening among staff.

Set of interview questions:

Intended questions for mental health workers

1. What is your job title?
2. What is your age band? (20-29), (30-39), (40-49), (50-59), (60-69).
3. How long have you been working in your role overall and in the organisation?
4. What is your professional role about and what kind of trainings have you had? What other training will you like?
5. How stressful is your role generally? What stress are you currently experiencing/have you experienced recently? How are you responding and what measures are you taking to manage or reduce your stress?
6. If you had a bad day at work, what do you do to relax and forget about what has happened? In what ways does this help you deal with stress?
7. How is your manager responding to staff experiencing stress? What is the process you are expected to follow? How helpful do you find this? What else would you want him/her to do?
8. If you became a manager overnight, what would you do differently in terms of how to support staff to manage their stress and why?
9. What is you experience with violent patients?
10. Thinking about workload, is it too little, too much or just right? To what extent does it fluctuate during the year?
11. In your team, when decisions are made, to what extent do you feel involved? Could you give an example?
12. How do you feel about the resources that you have to do your job? Do you have the right resources and is there enough of them? If not what is lacking and why?
13. How do you feel about your ward and the physical environment? What is working well and what isn't?
14. If you were in charge of the Trust, what would you do to reduce stress and why?

Intended questions for Occupational health specialists, HR and front line managers

1. What is your job title?
2. What is your age band? (20-29), (30-39), (40-49), (50-59), (60-69).
3. Tell me what your role involves?
4. What do you do to support staff experiencing stress at work?
5. On the intranet, there are policies around stress at work, how are these policies developed? Who is involved? Who is consulted? How are they communicated? How is compliance ensured?
6. To what extent are the policies implemented or implemented as intended? Could you give an example?
7. To what extent are these policies working? Could you give examples?
8. Are you able to provide support guidance to staff? What form does this guidance take? How helpful do staff generally find it? Could you give examples?

9. In your experience, what are the main sources of stress? Is there any staff group that is particularly prone to stress? If so which one? Why do you think this is the case?
10. To what extent are staff encouraged to share their concerns about work-related stress at an early stage, for example through regular supervisions and ad-hoc conversations?
11. Are there regular structures and activities to discuss pressures at work? If so what are they? How/by whom have they been developed? How are they being received by staff?
12. Do you have ad-hoc structures where staff are encouraged to talk to you about their concerns? If so, what are they? How frequent are they? How easy are they to access? How are they being received?
13. If a member of staff is experiencing stress at work, what happens then? What ought to happen?
14. What feedback have you got about the effectiveness of this protocol?
15. If you were in charge, what would you do differently to deal with the management of stress at work?

APPENDIX IX – EXTRACT FROM THE SICKNESS ABSENCE POLICY

Sickness Triggers:

3 episodes of sickness in a 12-month rolling period. An episode could be 1 day/shift or more (pro rata for part time employees); 2 episodes of sickness totalling 14 calendar days or more in a rolling 12 month period; or A noticeable pattern of absence giving cause for concern; Or any combination of the above.	If in the 12-month review period following Review point 1 an employee has the following further absence(s), they will be placed on Review point 2 of the short-term absence procedure: 2 episodes of sickness; or 7 calendar days or more of sickness.	If in the 12-month review period following the Review point 2 an employee has a further 2 absences, they will be asked to attend a further meeting to consider the future of their contract of employment.	An employee who has had their contract of employment terminated as a result of either sickness grounds has the right to appeal that decision. Please refer to the Trusts' Disciplinary and Dismissal Policy and Procedure.

APPENDIX X - GUIDE TO FLEXIBLE WORKING FOR MANAGERS

The NHS People Promise tells us that we do not have to sacrifice our family, our friends or our interests for work. We are a huge, diverse and passionate team, and as a team we are able to support and learn from each other to provide the very best care.

We need to support our staff with predictable and flexible working patterns, coupled with the knowledge that if we need to take time off we are supported to do so. For this vision to be successful we need to understand the barriers to changes so that we can work collaboratively to overcome them so that we remain an employer of choice.

Flexible working culture

XXXX promotes a supportive and flexible working culture. As Managers we need to engage with our Employees in open and honest conversations about flexible working regularly, and informally. This can be done in supervision, in team meetings, as part of a wellbeing conversation and annual appraisals. There is no single solution to how we achieve the balance between work and home, but we have developed this guidance as an enabler to the development of flexible working practices.

Local flexible working arrangements may need to be developed to reflect the principles of the flexible working policy and in partnership with stakeholder. Guidance and support relating to flexible working can be sought from your locality workforce representatives.

Flex at the point of recruitment

NHS staff are now able to access flexible working from their first day in post. Managers may have seen changes in the recruitment pack you have received when advertising your vacancy. This applies to all vacancies and should be conveyed positively and clearly in the advert. Consider using the “Happy to talk flexible working” branding offered free by Working Families.

When a post becomes vacant and there is a need to recruit, services should begin to consider the core requirements of the role and what flexibility can be incorporated. Consider how, when and where people can work, what are the hours and the activities that need to be carried out

Managers should engage with candidates early to determine their preferred ways of working and ensure that staff have all the information about the implications of different contractual arrangements so that they are able to make informed decisions.

Managers should be mindful that individual circumstance can change without warning and should prepare for such occasions.

Types of Flexible Working

There are many forms of flexible working, a list of examples is outlined in the Flexible Working Policy (HR)11 and also at the end of this guide.

Managers should understand and take into consideration that flexible working means different things to different people and be prepared to discuss differences based on individual circumstances.

Changes can be made on a temporary or permanent basis and that it must be recorded in ESR. The below list is not exhaustive and employee needs should be considered on an individual basis.

How to support a Flexible Working and Requests

Flexible working should become something that is normal practice, staff should be encouraged to have informal conversations at any time including during one-to-one supervision and wellbeing conversations. This can be a useful opportunity for the employee to explore possible options prior to making a formal request. Managers should sign post anyone considering a request to appropriate support and advice as required.

Flexible working requests should be submitted to you via the form on Appendix 2 of the Flexible Working Policy and must be logged in ESR. Appendix 2 has both a Employee and Managers Section that will be submitted to the ESR Team for inputting. **This must be done regardless of whether the application is approved or rejected.**

Timescales

When a member of staff submits a request it must be dealt with in a reasonable and timely manner.

- Managers must meet with the staff member to discuss the request within 28 days.
- Managers must have confirm your decision within 14 days of meeting with the staff member.
- Managers must have fully responded to the request within 3 months of the request – this includes the appeals process.

An employee may be accompanied at the meeting by a work colleague or a Trade Union representative at all stages of the process. We would encourage you to signpost staff appropriately when completing their application.

Exploring and Considering the Request

Managers must consider each request on an individual basis, taking into consideration any implications relating to equality. Advice is available from Locality/Directorate Workforce Teams in regard to all aspects of flexible working

Managers should meet with the member of staff to discuss their request in more detail within 28 days of it being submitted. Approach the conversation openly and creatively, explore together how the arrangements requested would work in practice.

Managers must explore all options available, engaging in positive conversations that explore solutions that are mutually agreeable. You should also establish if changing their area of work is something that they wish to be considered.

The individual making the request is not required to disclose their reason for the request or make a business case.

When a request is made in relation to a reasonable adjustment, Managers should make every effort to accommodate the request. In the event that adjustments cannot be met Managers must contact the Locality/Directorate Workforce Teams to discuss the rationale for not meeting the request.

Managers should not decline any requests at this stage and should take time to look at what needs to be reviewed or changed to accommodate the request or if you may need to escalate for further consideration.

Staff may be accompanied at the meeting by a work colleague or Trade Union representative.

Escalation and Consideration

If you are unable to accommodate the request in its original format you can propose and discuss alternatives.

In the event that an agreement cannot be reached you should see further support and discuss this with your Manager, Associate Director and Locality Workforce representative.

Consideration should be given to options outside of the applicant's current role.

Making a Decision

Agreeing a Flexible Working Request

If the request is agreed you should send a letter confirming all the details of the arrangement, this should include how the arrangements will be implemented. Timeframes, duration and whether it is a temporary or permanent change. All flexible working requests must be recorded in ESR.

It may be beneficial to carry out a trial period to see how the arrangements work in practice prior to making a contractual change.

Employees should be made aware of all of the implications to pay, annual leave and other benefits such as their pension entitlements prior to final agreement.

Rejecting a Flexible working Request

If a request is rejected clear business reasons must be provide as to why the request or a variation of the request cannot be facilitated. The reasons should be specific and include the rationale. Managers should include any alternatives that where discussed as part of this.

Any requests that cannot be accommodated should be followed up by a further meeting to discuss other possible options such as using the internal moves process to consider suitable alternative employment in a different ward or department where the request or a variation of it may be accommodated.

Senior Managers should be made aware when a request cannot be accommodated so that alternative options outside of the immediate team, ward or department can be considered.

Appeals Process and Hearing

A staff member may appeal against a Managers decision to not grant a flexible working request. Before getting to this point please ensure that you have explored all the options available to you.

Appeals must be received in writing and will go to your manager. (Manager of a higher position) within 14 days of receiving the decision that there request has been rejected.

The Senior Manager must hold a meeting to consider the appeal within 14 days of receipt of the appeal. An employee may be accompanied at the meeting by a work colleague or a Trade Union representative.

Your Manager must notify the staff member within 14 days of the outcome of the appeal. These time limits may be extended if agreed between the Manager and employee.

Upheld

If the appeal is upheld the flexible working request will be implemented. Managers will received written confirmation of the outcome of the appeal

Not Upheld

If the appeal is refused the Senior Manager must set out the grounds on which the refusal is based.

It is important to continue to have conversations and regularly discuss flexible working following the outcome and ensure the employee is aware that they are able to submit further requests.

All outcomes should be recorded in ESR and on the employee's personal file.

Ending or Changing Flexible Working Arrangements

As a Managers, you may request that flexible working arrangement change for operational reasons on a temporary basis to support patient care. This may be due to sickness absence, annual leave or some other substantial reason.

In the event that you request changes to a staff members flexible working arrangement, you must provide appropriate contractual written notice and have considered and discussed alternative arrangements.

Recording Flexible Working Requests

The Agenda for Change handbook stipulates that all organisations must log and monitor flexible working request, irrespective of the outcome.

In may seem unnecessary to record requests formally, but it can provide your staff with peace of mind knowing that there is support available if and when the need it, even if it is only occasionally.

Managers may already be aware of someone's need to work flexibly through regular conversations and we would encourage this to be documented and recorded.

The Trust will be monitored and asked to report on flexible working. Details of staff with a flexible working arrangement in place should be sent to XXXXXX

Copies of all applications and correspondence should be retained on the employees' personal file by forwarding copies to the relevant locality workforce representatives.

Managers should retain copies to support with the review process.

Reviewing Flexible Working Arrangements

It is important to ensure that the working arrangements are reviewed regularly. This can be done as part of regular supervision, wellbeing conversations and annual

appraisals. As a minimum Managers should review any new arrangements informally at 6 months and conduct a formal review at 12 months thereafter.

It is important to remember that personal circumstances can change at any time and without warning and we need to provide support to our employees when this happens. This may involve making adjustments or providing support via occupational health.

Employees are able to request changes to flexible working arrangements at any point, however any variations to flexible working arrangements are subject to mutual agreement with you (the manager).

When reviewing flexible working arrangements you may wish to consider how the arrangements are working for both the employee and the service: Are any adjustments needed that could improve this?

Tools to Support Flexible Working

The Trust is committed to supporting staff so that they can attend work and this means there will be occasions where as a manager that you need to make adjustments to a person’s role so that they are able to carry out their role.

Communication can be your greatest ally when it comes to supporting flexible working.

Discuss flexible working with your team and make it a team effort. Encouraging flexibility and different ways of working can uncover many benefits when applied and shared fairly, such as increased commitment, engagement, reduced conflict and reduced sickness absence.

Get to know your staff and understand their personal circumstances and individual preferences, it may not be realistic to meet all of their expectations but engaging with them to discuss their needs supports their wellbeing. Your staff may feel anxious about new ways of working, taking about it provides clarity allowing them to prepare.

Discuss the potential risk and challenges for the team about working flexibly and work together to overcome them.

Align your expectations, what are the targets and goals. If someone is reducing their hours this should be reflected in their expected outcomes.

Have a backup plan in case of emergencies or unexpected changes, consider implementing a buddy scheme.

Supporting those with Disabilities

To support disabled staff a Disability Passport and guidance has been developed to support staff and managers in the workplace. We would encourage managers and staff to utilise the passport to support the identification and implementation of any reasonable adjustments.

Advice is available from Locality/Directorate Workforce Teams in regard to all aspects of support with reasonable adjustments.

The Disability Passport is part of (HR)10 Sickness Absence Policy, Appendix 4 and 4B

Supporting those with caring responsibilities

Up to 1 in 3 people in NHS workplaces is a carer in addition to their paid employment and this is set in increase in line with the UKs aging population. Carers UK estimates that approximately 72,000 people have left work in the NHS due to being unable to balance their work and caring responsibilities

Your responsibilities may be as a parent or guardian or maybe as a care provider to a friend or relative who needs additional support. It's becoming more common for someone to be caring for both a child and an elderly family member which is increasing the obligations we have in our free time. Sometimes the arrangements are temporary and sometimes they will be longer term.

NHS England provide some practical tools and resources here (accessed 18.11.2021)

It's important to remember that it's not unusual for someone to not identify themselves as a carer, so it's fundamental that we get to know our staff and understand their individual circumstance in order to support them in an a appropriate way.

To support staff an Employee Passport and guidance has been developed and we would encourage managers and staff to utilise this to support the identification and implementation of any support or changes that may be needed.

The Employee Passport is part of (HR) 11 Flexible Working Policy, PGN 01 – Carer Support for Trust Employees.

Considering a Flexible Working Request – things to think about

Where does the work need to be done?
Where does the role holder need to be to support their client - does it need to be in person or can the work be done remotely? How often does a team need to be together in the same room
When does the work need to be done?
When does the person need to be available to client – all or part of the role, Can the role operate flexibly, consider flexing start and finish times, averaged or compressed hours Is there anyone who can substitute or buddy up when the role holder isn't around
How much work does the role involve? –
Important when staff are working part time or reducing their hours – how is work distributed Consider where workload can be redistributed to Are all tasks necessary or can some to be stopped Is Job Sharing an option

APPENDIX XI – NHS BEREAVEMENT POLICY

Our NHS People Understanding different bereavement practices and how our colleagues may experience grief 21st December 2020 Drafted by the National Health and Wellbeing Team, NHS England and NHS Improvement

Considerations for line managers:

We are all individuals and the ways in which we deal with death and grief can vary. When a colleague approaches their line manager to advise of a bereavement, line managers should feel equipped to support them in a compassionate and empathetic manner. Line managers are invited to use this resource to learn more about the bereavement practices of different religions and cultures, and how they can then support colleagues experiencing grief or bereavement, noting the cultural differences experienced by our diverse workforce, all of whom have been subject to government restrictions impacting on their normal grieving practices.

Our diverse workforce also includes a number of colleagues who have family members living abroad and may need to travel abroad to attend a funeral. Allocating one day of compassionate leave to attend the funeral in this instance would not be beneficial, and consideration should therefore be given to the time it may take for colleagues to travel abroad to attend funerals. It is also likely that given the current pandemic and restrictions on travel, colleagues may not be able to visit family for several months and therefore may wish to take compassionate leave later in the year, when they are able to mourn with their family. Line managers must not assume that because of an individual's affiliation to one specific belief system that they will follow all of the principles outlined in this resource.

Communication is key to finding out what matters to them as an individual. Similarly, our NHS colleagues may relate to more than one culture or religion and the way in which they practice their beliefs may be different to what is outlined in this resource. As a line manager it is important to get to know your colleagues and remember that each person will have different needs.

Statutory bereavement or compassionate leave

Anyone classed as an employee has the statutory right to time off if: their child is stillborn from 24 weeks of pregnancy or dies under the age of 18 (in April 2020, a new legal right called Jack's Law mandates that parents who suffer the loss of a child aged under 18 will be entitled to two weeks' statutory paid leave), a 'dependant' dies, for example their partner, parent, child, or someone else who relied on them.

There is no statutory recommendation on how many days an organisation should offer staff for bereavement or compassionate leave, however the NHS Terms and Conditions and a number of local HR policies suggest five working days, at the discretion of a line manager. This means, for example, if a bereavement has particularly impacted the health and wellbeing of a staff member, if they need time off to adjust to changes to their caring responsibilities, or if they need additional time to travel abroad to attend a funeral, line managers can compassionately approve the extension of leave to support that individual.

Line managers are encouraged to demonstrate compassionate leadership when colleagues request bereavement leave, taking into account the personal situation of the colleague asking for support. It is possible that the colleague requesting compassionate leave is wishing to attend the funeral of an auntie who raised them, and therefore the loss to them is like that of losing a parent or guardian. Demonstrating compassionate leadership will create cultures where staff feel supported at work and where colleagues feel able to openly talk about their beliefs and experiences, without concern of being judged.

Tips for line managers and colleagues

When a colleague informs you that they are going through a bereavement.

• Express your condolences and make it clear that they are not expected to work on the day that their loved one has died.

• Be aware of your local HR policy on bereavement or compassionate leave, and speak with the colleague to consider how much time they may need to make funeral arrangements or fulfil religious or cultural traditions, such as attending a funeral or care for dependants.

• Identify the way in which they would prefer you to keep in touch.

• Ask them how much they would like you to tell their colleagues about their bereavement. When a colleague is ready to return to work.

• It is possible that a colleague may request a phased return to work or to work flexible hours to help support their transition back to work. In this instance, line managers should remember that each colleague is different and how you support them will vary dependant on their individual circumstance.

• Be open to flexible working provisions. Flexible working options can be particularly helpful to bereaved employees in the short and longer term, particularly if the bereavement has led to changes in personal circumstances, such as caring responsibilities.

• Consider a phased return to work. A phased return to work is a way of enabling employees to return to their duties in a gradual way. It is typically adopted following illness or injury through an occupational health referral, but it can also be helpful for providing a supportive and manageable return for those that have been bereaved. If a

bereaved staff member returns to work on a phased basis, they will work a reduced number of hours at first, followed by a gradual increase in workload until they reach their normal number of hours. A phased return to work usually lasts anywhere between two and six weeks but can be extended if necessary. A phased return to work plan should cater to the bereaved staff member and their specific needs.

• Be sensitive to requests for time off. It is important to be sensitive to and accommodating of requests for time off where possible, especially around anniversaries or other special memorial events.5.2.6 Recognising that the very nature of domestic reasons leave means that it is unlikely to be possible to submit a request in advance, the request should be made on the first day the leave is required and within one hour of the normal time of commencing duty or, if this is not possible, at the earliest opportunity. As far as possible, the employee should be the person to make contact with the manager, but in certain circumstances it is recognised that this may need to be done by a third party.

Tips for line managers and colleagues

When a colleague returns to work after a bereavement.

• Talk to the colleague about their wellbeing. If they are working a phased return or flexible hours, check in with the colleagues to ensure the arrangement is working for them or if amendments need to be made.

• Offer support where appropriate, but do not take offence if they do not accept further help. It is possible they will have family or friends already helping them for example, or they may prefer to take care of everything on their own. Respect their decision but be there for them if they change their mind.

• Remember that every emotion is normal and there is no right or wrong way to experience grief.

• Listen to them if they wish to talk. If someone opens up to you about how they are feeling, it can be difficult to know how to respond. Just listening to them can be very helpful.

• Signpost support where appropriate. If you feel that a bereaved employee requires more support than you or other colleagues can provide, it might be best to recommend professional therapy or access to services such as Occupational Health or with their GP. There are also a number of bereavement support and grief counselling organisations that can help people with different types of loss, including loss of a child and bereavement by suicide.

• A bereaved person often has lots of support in the first days and weeks of their loss, but this support can fade away after a few months. Bereaved people can feel grief for the rest of their life and find it difficult to manage without their loved one for years after the death. Consider making a reminder note to check in with the person at intervals, when grief can re-present